FUTURE DIRECTIONS

FOR SASKATOON'S HOSPITALS

A Plan for the Consolidation of Acute Care Services

A STUDY FOR THE
SASKATCHEWAN COMMISSION
ON DIRECTIONS IN HEALTH CARE

July 31, 1990

Dr. R. G. Murray
Chairman
Saskatchewan Commission on Directions in Health Care
Saskatoon

Dear Dr. Murray,

In accordance with our instructions from the Commission, we are pleased to present to you our analysis of the hospital services in Saskatoon and our recommendations for changes.

Each of us appreciated the opportunity to participate in this study of the Saskatoon hospitals and the University of Saskatchewan College of Medicine, and we sincerely hope that our work will result in a reorganized, revitalized and forward-looking hospital system for the city and the province.

Yours sincerely,

Dr. John W. Atkinson
Chairman

Ralph Coombs
Member

John MacKay
Member

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Executive Summary

This study results from a review, by an external panel, of the acute care hospital services in Saskatoon.

The panel was formed by the Saskatchewan Commission on Directions in Health Care after it was asked by the Minister of Health to propose a plan for the consolidation and rationalization of hospital services in Saskatoon. The object of an external panel was to have an objective look at the present acute care services and propose a realignment to:

- increase the scope of hospital services to meet the needs of the future.
- create an integration of services that would enhance quality and better use the available resources.
- develop a clinical milieu in which academia would flourish.

The panel's mandate was clear and open and its members began their task with no preconceived solutions in mind.

In order to ensure adequate and appropriate involvement of the three hospitals, each was asked to establish a liaison group with representative members. A conjoint group of senior representatives from the three hospitals and the College of Medicine, University of Saskatchwewan, was formed to deal closely with the study panel during the course of the review.

The panel reviewed all prior studies and relevant documentation as provided by each liaison group. Interviews were held with all interested groups and individuals.

It was the hope of the study panel that such close involvement with the four stakeholders would result in a consensus for consolidation to meet the three goals, approval of the model for realignment of services which the panel had developed, and an environment in which the desired consolidation could be implemented around this model.

Despite moments of optimism, the panel realized that consensus was not achievable in the atmosphere of distrust that was so apparent and with the entrenched mindset of many of the hospital representatives.

This very lack of consensus confirmed to the study panel that an external authority was necessary to implement this consolidation and the model and thus meet the changing needs of the future, in particular for the services of geriatrics, mental health and rehabilitation, and address the present and future requirements of the College of Medicine.

Chapter I: The Situation

Introduction

The western world is reviewing and tuning the entire health care system. Driving factors for change are the need to measure and ensure the best quality of care achievable and the attainment of this goal at minimum cost to society.

Central to this ongoing process is a review of acute care hospitals in the system. Everywhere there are examples of the downsizing of institutional care of admitted patients, combined with a movement to day care within the hospital or alternative care outside it.

At the same time, rationalization of institutional care is occurring. The bringing together of clinical services from two or more hospitals allows for economies of scale, but more importantly, creates a more effective volume of cases such that:

- the scope of care is enhanced;
- the quality of care is augmented;
- academic needs of colleges of medicine are better addressed.

This international trend has bypassed Saskatoon.

Previous efforts

It has not been for lack of trying, however. For more than a decade, as it funded similar services on several sites and observed gaps in services, the Department of Health pushed in vain for voluntary rationalization and co-ordination among Saskatoon's three hospitals. Occasionally - as in early 1987 when the Department initiated meetings with hospital representatives which actually identified ophthalmology, otolaryngology, obstetrics, pediatrics and orthopedics as potential areas for rationalization - progress has seemed possible. But it has never occurred.

Centres of Excellence

Perhaps the best hope was the "Centres of Medical Excellence" announced in 1989 by the Minister of Health, the chairmen of the hospital boards and the Dean of Medicine of the University of Saskatchewan.

The hospital boards publicly expressed their commitment to the concept and challenge, accepting that attitudes, physical locations and past practice could no longer get in the way of delivering the highest quality care. They agreed that such care required Centres of Excellence that made the best use of technology and expertise.

When the announcement was made, hospital and College officials spoke of being "deeply committed to the co-operative partnership being forged", "firmly committed to an integrated hospital system and medical teaching environment". They expressed the conviction that "the timing is right for action", that "this approach will result in first-class health care for Saskatchewan people", that it would "provide the kind of clinical opportunities our medical students need to prepare themselves for tomorrow".

Despite such deep and firm commitments, that initiative, too, collapsed before the general obduracy and entrenched power structures of the hospitals. "Centre of Excellence", as a term, took on a pejorative meaning that detracts from the serious attention it deserves.

The problem of Saskatoon's multiplicity of hospital services was then handed to the Saskatchewan Commission on Directions in Health Care. At that time, late in 1989, it was in the final stages of its examination of health care in the entire province.

The Commission appointed a study panel of outside experts with diverse backgrounds in health, awareness of the forces reshaping health and delivery systems, and experience with hospital amalgamations elsewhere. During the four-month study, the outside experts were able to spend 20 days in Saskatoon meeting with hospital and College of Medicine officials.

Study panel

Three members were appointed:

• as chairman, **Dr. John W. Atkinson** FRCP(C) of Ottawa, president of John Atkinson Health Care Professionals Inc., past president of ABL

Medical Management Consultants Ltd., associate professor of anesthesia, University of Ottawa, advisor to the Canadian Medical Association Committee on Hospitals and chairman of the Ontario Medical Association Committee on Hospitals.

• **Ralph Coombs** FCCHSE of Calgary, president of Foothills Provincial General Hospital since 1973, president of the Alberta Hospital Association 1977-78, president of the Association of Canadian Teaching Hospitals 1978-79.

• **John MacKay** of Vancouver, first chairman of the Board of Trustees of the merged University Hospital, former chairman of the University of British Columbia Health Sciences Centre Hospital Board of Trustees, director of the British Columbia Health Association, former president and director of Extendicare Ltd., founding president of Centennial Hospital Linen Services, a joint project of 12 Toronto-area hospitals.

Mandate

The study panel was asked to:

- review in depth present policies and practices for managing and delivering hospital services in Saskatoon, and identify opportunities to enhance their effectiveness and efficiency.

- develop options for professional resources, treatment rationalization, auxiliary services and management co-ordination to reflect future demands and developments.

- recommend to the Commission changes in the hospitals' mandates to produce more specialization of services, with specific recommendations for their future complementary operation.

Process

Step 1: Work with the stakeholders - the three hospitals and the College of Medicine - to bring out the recognized need for change and reach agreement that the *status quo* is not in their best interests.

Step 2: Design a model for clinical services that would establish new opportunities for a higher standard of care to be delivered to Saskatoon citizens, facilitate a balanced, reasonable distribution of local resources, and create the critical mass in programs and people necessary to attract and retain needed medical manpower.

Step 3: Once the model was accepted, the stakeholders would design and commit themselves to an implementation process.

The study panel was not motivated by the desire to save money for the Department of Health, but by its determination to address the questions of the availability and quality of hospital services in Saskatoon. It believed, however, that the reallocation of existing resources should allow for the provision of new services at no extra cost. In other cities where such consolidation has occurred, there have been financial savings. If that should occur in Saskatoon, it would be an extra benefit.

As its first move, the panel established a conjoint group with senior representatives of the stakeholders - chairmen of the hospital boards, presidents of the hospitals, chiefs of the medical staffs, the Dean and Assistant Deans of the College of Medicine - as members.

After discussion, all accepted the following assumptions as principles to guide the process, describing them as "givens":

Agreed-on assumptions

- The role of hospitals in the health care spectrum is changing.
- Change in institutional care is needed in Saskatoon.
- Quality of care is the primary issue.
- Educating health care professionals is important and a provincial mandate for Saskatoon.
- There are unmet clinical needs in Saskatoon.
- There are unmet educational needs in Saskatoon.
- Reorganizing institutional care will meet some of these clinical and educational needs and allow resources to be reapplied to meet future needs.

- All hospitals should have an educational role.
- Reorganizing institutional care will improve quality.
- "We" - the existing team - can do it!

The conjoint group explored the idea that Saskatoon has too many hospital beds if the current configuration of services continues. It explored various options for authority among the hospitals, including the merger of one or more hospitals and the possibility of one board put in place above the existing boards. It accepted that a shared manpower plan is needed, and that the hospital/college affiliation should lead to equitable teaching roles.

As the process proceeded, as the study panel and the conjoint group examined the information readily provided by the stakeholders and began to flesh out a model for reconfiguring hospital services in Saskatoon, five serious problems were identified. It was agreed that any model must address these five problems.

1. In many cases, the critical mass of patients required for a hospital service is not available.

2. There is some duplication of clinical and non-clinical services at the hospitals.

3. At the same time, there are unmet clinical needs.

4. There is no provincial or city-wide strategic planning or any specific planning to respond to changes in health care trends, technology or patient care.

5. The first four problems are affecting the College of Medicine and may compromise its accreditation.

Chapter II: Examination of the Situation

Background

Saskatoon is a city of approximately 185,000 people with three general hospitals: Royal University Hospital*, begun in 1955; Saskatoon City Hospital*, begun in 1906 as Saskatoon Municipal Hospital; and St. Paul's Hospital*, operated by the Grey Nuns since 1907. (See Appendix A).

In all, these three hospitals serve more than 500,000 people, for patients are referred to each of them from physicians and hospitals throughout central and Northern Saskatchewan. Each is a general hospital with a limited amount of specialization, and each teaches health care practitioners. They have similar missions.

Together Saskatoon's three hospitals spend 30% of the total spent by the provincial government on hospitals in Saskatchewan - $175.3 million in 1989-90. As of May 1, 1990, their total complement was 1,406 beds, and in the year ending March 31, 1990, they treated approximately 1.1 million inpatients and outpatients combined and performed more than 18.4 million diagnostic tests. (See Appendix E, Table 2.)

** For the sake of brevity, the hospitals are hereafter referred to as RUH (Royal University), SCH (Saskatoon City) and SPH (St. Paul's).*

Demographics

1. Saskatoon's population is expected to total 188,819 in 1991, a 5.9% increase over 1986, according to *A Population Projection for Saskatoon 1991 and 1996* done by the Policy and Research Branch of the City of Saskatoon Planning Department in September 1989. It should reach 202,233 in 1996.

2. A smaller proportion of that population will be under 19, 27.6% in 1996 compared to 28.8% in 1986. However, the actual number of persons under 19 is projected to increase by 8.4%.

3. According to *A Population Projection for Saskatoon*, birth rates increased marginally over the 1976-1986 period and the age-specific trends are for slightly lower rates among women 15 to 29 and slightly

higher rates among women 30 to 39. There is no reason to anticipate a significant change in these trends.

4. Saskatoon's fertility rate increased marginally from 1976 to 1986 and will continue the same trend. It is projected at 1.82 births per 1,000 women in 1991 and 1.85 in 1996, reflecting the city's steady population growth.

5. The proportion of the total population in the 60-plus age group is not expected to change significantly. It was 13.1% in 1986 and will be 14.1% in 1996. However, the number of persons over 60 is expected to increase by 22.6% in the next six years.

6. The demographics of Northern Saskatchewan, which is served by Saskatoon hospitals, are different in many ways. The elderly make up a much smaller proportion of the northern population, and there are proportionately more young people. The area has many health problems, particularly among its large Indian population; the rate of infectious diseases, including respiratory infections, tuberculosis, middle ear disease and sexually-transmitted diseases, is high, the birth rate is at least double that of the south, and the infant mortality rate is much higher. Separations and patient days per 1,000 among Saskatchewan Indians in 1987-88 were nearly 2.5 times the rates for non-Indians. Registered Indians were responsible for 9% of separations at RUH, 7% at SPH and 5% at SCH.

Although these facts about Saskatchewan's population are widely known - they were examined in depth in the report *Future Directions for Health Care in Saskatchewan* - Saskatoon's hospitals have not made comprehensive plans to adjust to their realities.

The Problems in detail

1. Lack of a critical mass

Critical mass is the quantity of cases or services that is necessary to attain satisfactory quality and efficiency. "Such a critical mass attracts competent staff, allows this staff to remain competent, makes it more likely that equipment will be up-to-date, promotes research and encourages a motivating professional atmosphere." (Ralph W. Sutherland and M. Jane Fulton: *Health Care in Canada*, p. 146).

Splitting services and cases among two or three hospitals in a community the size of Saskatoon - even taking into consideration the vast area of Saskatchewan which its hospitals serve - makes it almost impossible to attain a critical mass. Without it, say Sutherland and Fulton (p. 155), there will be increases in unit cost because economies of scale are lost. There will be decreases in quality because it is difficult to attract specialists, maintain skills when service volume is low, justify purchase of up-to-day equipment, provide 24-hour coverage, do research and obtain peer support. And there will be decreases in the number of specialized administrative services such as data handling, inservice education and employee group benefit packages.

The College of Medicine suffers particularly from the lack of a critical mass of patients to provide the best teaching situation for its students. In his report, *Towards a New Beginning*, Kerr White described the College's "need to provide both undergraduate and postgraduate students with opportunities to study and care for those types of patients and health problems they are likely to encounter at the levels of primary and secondary care". He cited two earlier reports which spoke of the need to distribute among all three city hospitals "both the demands of educational resources and the opportunities to learn from a full range of patients and their problems". As a tertiary care centre, RUH alone is not enough. Also, it is overstretched with specialty and research programs and doesn't have the critical mass to support all specialty programs.

2. Duplication of services

Maternity

Each Saskatoon hospital offers maternity services, for a total of 94 beds set up for maternity on May 1. That day, the occupancy rates were: RUH - 83.5%; SCH - 45%; SPH - 85.2%.

Though births occur in each hospital, the only neonatal intensive care unit is at RUH. In 1989, 45 newborns had to be transferred from SCH and SPH to RUH, separating mother and child and causing trauma to both. In other cases, mothers and babies have been moved together from one hospital to another when the mother wants a tubal ligation immediately after delivery. In addition, cases are reported of women in difficult labor and requiring epidural (regional) anesthesia begin transferred between hospitals.

Having maternity care on three sites means that nowhere does the concentration necessary to meet today's standards of care and patient safety exist. This is particularly true in terms of a critical mass of caseload and clinicians necessary to maintain skills. National standards set 3,000 as the minimum number of deliveries required each year to ensure quality of care and patient safety. Saskatoon had 4,892 deliveries in 1988-89: 1,730 at RUH, 1,067 at SCH and 2,095 at SPH. (See Appendix E, Table 8.)

Nurses told the study panel that because the three hospitals have differing standards and protocols for requesting an obstetrical consultant, prolonged labors have been caused.

Pediatrics

This clinical service is duplicated in each hospital and is not efficiently used. Occupancy rates on May 1 showed SCH at 53.1%, SPH at 56.6% and RUH at 68.4%. Not all three have the complete service, yet all have staff specializing in the care of pediatrics. System-wide, this means such staff and other health resources specific to the care of pediatrics are not used to their maximum efficiency.

Pediatrics is an area of dramatic change. Admissions are decreasing; only sicker children are treated as inpatients. Outpatient, ambulatory and emergency care is increasing as hospitals are used as walk-in clinics as an alternative to physicians' offices, and physicians refer to hospitals for diagnostic services, laboratory and X-ray.

As one Saskatoon pediatrician told the study panel, these changing trends are not met with services fragmented among three hospitals, with not only duplication but triplication of services (all incomplete), to the detriment of quality of care, education, training and research. A bad situation is made worse by problems of underfunding and having to divide relevant budgets, already meagre, three ways.

Gynecology

This service is provided in each of the three hospitals. Occupancy rates - RUH 39.8%, SCH 67% and SPH 88.8% - show that there are factors in the system causing a wide variation in the use of beds. In total, 80 beds are dedicated to gynecology at the three hospitals; only 49 were in use May 1, 1990.

Ophthalmology

This service is provided at each hospital. On May 1, 1990, beds set up were RUH 12, SCH 7, and SPH 5, for a total of 24. The occupancy rate again varied; 33% of the beds were not occupied. SPH and SCH are discussing consolidating their services. SPH does mostly cataract surgery.

Creating a centre for ophthalmology, stressing both teaching and service, would offer many benefits and solve many problems, as outlined to the panel by city ophthalmologists.

- Consolidation and integration of service would increase quality of care and build into the system the quality assurance that is now lacking, with the department head overseeing it.

- Consolidation would help solve the problem of tight budgets with no funds for updating photo and computer equipment. Duplication of equipment purchase could be reduced and dollars directed to upgrading.
- Consultation and emergency services for other hospitals could be organized and implemented so there is 24-hour availability.
- Space could be redesigned to provide an efficient flow for patient services, both ambulatory and inpatient, and room for clinics and support activities, space now lacking at the hospitals.
- There would be a dedicated and specially trained staff. Now many operating room assistants do not see enough ophthalmology to be proficient in eye surgery.
- Bulk purchase for lenses and other supplies would be cost-effective, and there could be backup inventory for equipment that breaks.
- A state-of-the-art centre with a critical mass of patients and opportunities for teaching, research and specialization would attract ophthalmologists to overcome the present shortage, and provide for a situation in which all ophthalmologists want productive relationships with the College of Medicine.

Emergency rooms

The study panel tried through interviews to ascertain whether three full-service emergency departments were necessary for Saskatoon. Acording to Sutherland and Fulton (*op cit*), 75% to 90% of patients who come to emergency departments have problems (a) that are not life-threatening, (b) which can be dealt with in a relatively ordinary office, treatment room or minor surgery, and (c) whose treatment can be safely deferred for a few minutes or hours (p. 312).

Evidence is now conclusive, Sutherland and Fulton say (p. 309), that high-quality emergency care requires a different model than the general-service department. Such services are a standby network which must be ready for head injuries, eye injuries, chest injuries, burns, respiratory difficulties and severe blood loss, and each requires its own mix of specialized services. "It is economically unreasonable to maintain the highest level of standby capability in any institution at which very few

complex cases arrive per month or per year. It is also impossible to maintain the clinical skills of the medical, nursing and other staff unless there is a reasonably steady arrival of cases requiring those special skills." (p. 309.)

In Ontario, four categories of hospital emergency department have been proposed: comprehensive (the most sophisticated would be called a trauma centre), major, general and basic. British experts believe that one million people is the proper base for one highly sophisticated trauma centre with a full range of specialized services available 24 hours a day seven days a week.

The panel was told that approximately 50% of all emergency visits in Saskatoon are for pediatrics; this would clearly justify creation of a special pediatrics emergency department. If that occurred, the demand for emergency services would be much less.

Departments of pathology, including laboratory services

These are now fragmented among the three hospitals and the lack of a critical mass at any one of the three makes it difficult to use staff efficiently to perform the more esoteric and special tests. Therefore these are sent to out-of-province laboratories, adding to delays and, in some instances, cost.

Across North America, a movement to centralize laboratory facilities has accompanied the increase in volume and sophistication of laboratory activity. The availability of automated equipment capable of producing a high volume of tests at a low unit cost has stimulated interest in expanding patient volume to effect economies of scale. Use of computer hardware and software systems for data storage and analysis and for communicating clinical and management information has made sharing more feasible. (Montague Brown and Barbara P. McCool: *Multihospital Systems*, p. 113.)

Present problems in Saskatoon include a shortage of biochemists among the three hospitals. In addition, pathologists' salaries are not competitive with other provinces and Saskatoon may face a shortage in the future.

Support departments

All three hospitals have employee benefits and personnel departments which attract, develop and retain able and loyal employees, provide equal opportunities and a high degree of training, and provide employees with compensation and benefits that are the standard norm or above.

Each management/support department requires a skilled staff and resources to ensure the hospital is adequately staffed with full-time and part-time employees.

As the province faces shortages of nurses and skilled staff such as physical and occupational therapists and speech pathologists, caused by lack of resources and the lure of higher salaries and innovative benefits elsewhere, it is reasonable to assume that each hospital will dedicate resources to designing new benefits. It would be efficient to not duplicate services but to combine efforts so solutions could be shared. Examples of solutions: child care for employees, job sharing, flexible hours and pooled resources.

3. Unmet needs

Maternity

The system lacks consistent and immediate accessibility to anesthesia, neonatology and ultrasound on a 24-hour basis. An example is the problem of availability of epidural services (regional anesthesia during difficult delivery).

There is no co-ordinated community nursing liaison program which could ensure good follow-up care and treatment in the home. A new approach to the management of hyperbilirubinemia involves the use of home phototherapy and monitoring of the bilirubin levels. Also, mothers who require additional training in care of the newborn or breast feeding can be discharged and the teaching provided in the home setting.

There is no standard quality assurance program that would monitor utilization and practice patterns. One area of practice that deserves further study is the rate of deliveries by Caesarian section which, at 26% for the three hospitals, is higher than the national rate of 20%.

Pediatrics

Perhaps the most important problem is the lack of a dedicated pediatrics emergency service. Most family physicians have no privileges at RUH which has the only pediatric service which can cope with serious emergency problems. SPH and SCH are not equipped to handle major pediatrics emergencies due to the lack of tertiary services.

Consolidating pediatric care at one site would provide the critical mass which would justify a dedicated pediatric emergency room with tertiary support services and staff.

It was explained thus to the study panel: "Most families are under the care of family practitioners and they do not have privileges at RUH, because it hasn't enough beds to support all physicians. The parents of a child who is seriously ill or hurt call the family practitioner, who assesses the child in the emergency room at SPH or SCH. If the family practitioner determines that he/she can manage, the child is admitted to SPH or SCH; if not, if the case is very severe, the child is admitted to RUH. The problem is the long wait to get appropriate care and the possibility that the patient's condition can worsen. "

Another problem identified to the panel is the lack of a transport team for pediatrics. There are two services: neonatal transport and general transport. Pediatrics are treated in general transport.

Space problems mean that general pediatric services and most sub-specialties have to be restricted in scheduling and there are no specialized ward areas to accommodate the specific age groups within pediatrics and the special social needs of each. A new ward is especially needed for adolescents. There is no organized approach for parents to get access to

community services for children and ambulatory and outreach services for children are not well-developed.

Geriatric services

The Geriatric/Rehabilitation Task Group told the study panel that geriatric services are underdeveloped in Saskatoon. It had made an inventory of available services and identified major gaps in institutional care, community-based services and availability of skilled manpower.

Institutional care was found to lack physical space in which to expand assessment and treatment of patients. The current assessment process between institutions is not always efficient and is sometimes redundant.

Community services lack community-based day-care services to care for the frail elderly patient or the patient suffering from dementia who needs a protective environment during the day. There are no resources to provide speech and physical therapy and social services in the home. A network of community services is needed in the rural areas outside Saskatoon.

Manpower shortages were identified. Needed are geriatricians, geriatric psychiatrists, physical, occupational and speech therapists. And the task group outlined the need for all health care professionals to expand their knowledge of the special needs of geriatric patients.

The task group and the study panel agreed that this inventory was a good beginning of the planning process. They agreed that an interdisciplinary group of experts from both institutional and community settings should continue and develop a plan for a comprehensive network of care that would fill the present gaps and expand existing services so geriatric patients would be treated at the right time and in the right care setting.

Physical rehabilitation

This is another unmet need in Saskatoon, with similar characteristics to geriatrics. It is underdeveloped due to lack of skilled physical therapists,

occupational therapists, and speech and language pathologists. Only RUH has a designated Department of Rehabilitative Medicine; SCH and SPH are developing more capacity. Rehabilitation is also offered through Parkridge Centre and the RUH outreach program. However, these efforts just scratch the surface.

The lack of rehabilitation and therapy services inhibits and frustrates efforts to maximize patients' potential for independent living, which means participation in all activities of daily living including personal hygiene, dressing, feeding, communicating, walking and socializing

All types of therapists - physical, occupational, speech, respiratory, recreation - are needed. So are outpatient services for both acute rehabilitation and maintenance programming. A head injury unit, home visit rehabilitation nursing, access to a neuropsychologist, special counselling for young spinal cord injury patients and establishment of a school of occupational therapy are other needs.

Mental health

As *Future Directions on Health Care for Saskatchewan* reported, this province was once considered an innovator and leader in the mental health field but has failed to keep pace with the trends in care and the needs of the community, both locally and provincially. The Psychiatric Work Group, which has representatives from all hospitals, the College of Medicine, the Mental Health Clinic and Hospital Services Branch, Department of Health, agrees that psychiatric services are in a crisis.

The work group indicated to the panel that Saskatoon has the lowest ratio of psychiatric beds to population in Canada. It also pointed out the potential for a hospital with more than 300 beds to have patients with severe medical conditions and concurrent psychological problems who require services in a psychiatric unit. The work group also stated that the current system is deficient in space and research facilities and needs to expand programs for evaluation and assessment for treatment-resistant patients, and to expand forensic psychiatric medicine.

Two hospitals, RUH and SCH, offer psychiatric treatment and inpatient occupancy is extremely high. This means patients' treatment may be delayed and they are often disconnected from their families and forced to go out of the area or even out of the province for services. Psychiatric inpatient beds, day care facilities, outpatient services and a community network service are needed now.

Specifically, Saskatoon needs at least 50 to 60 more beds for psychiatry, in addition to the existing 69. This would ensure appropriate beds for pediatrics, adolescents, geriatrics and the general adult population. These programs would require linkage to community crisis intervention, residential programs and community services.

. **Lack of strategic and specific planning**

Strategic planning is a continuous process aimed at keeping an organization as a whole appropriately matched to its environment (Samuel C. Certo and J. Paul Peter: *Strategic Management*, p.5). Such planning requires strategic management, which involves a series of steps: performing an environmental analysis, establishing organizational direction, formulating and then implementing organizational strategy and exercising strategic control (Certo and Peter, *op cit.*).

Individually, Saskatoon hospitals may have used strategic management and planning, but they have always done both in isolation from one another. They have no agreed-upon overall plan for city or regional programs, manpower and bed needs, technologies, support services or evaluation, and have not been required by the provincial government which funds them to produce and adhere to such plans.

That makes it easier to understand that $199 million has been invested in physical plants in the last few years - redeveloping RUH ($24 million), expanding and developing SPH ($52.7 million) and rebuilding SCH ($122 million) - and that each project was planned in a way that perpetuates the existing arrangement. The provincial government, lacking a plan of its

own, was unable or unwilling to compel strategic planning among the hospitals.

There can be no doubt that the lack of a regional planning strategy has helped bring about the present situation of too many hospital beds in Saskatoon. The new SCH facility is rising close to downtown Saskatoon, amid concern about how its beds will be used. The government has put a hold on the construction of 157 pediatrics, obstetrics and general medicine beds, creating uncertainty about the hospital's identity. In the meantime, some services at the other two hospitals are crowded and staff are studying solutions to that crowding. Unless things change quickly, one of the proposed solutions is likely to be more beds. For example, the new maternity unit at SPH has high occupancy rates, while SCH is experiencing only a 45% occupancy in maternity.

Since Saskatoon's three hospitals don't plan together, it is not surprising that their relationships with hospitals in other communities grew in an *ad hoc* way and are unplanned and unorganized. There is no rationalization between Saskatoon hospitals and those in Regina, or indeed with any regional hospitals.

The operations and planning of Saskatoon hospitals in many cases ignore Saskatchewan's new demography. For example, because the province already has the largest proportion of elderly in Canada, much more attention needs to be paid to geriatric care at both the hospital and community levels. One body needs to orchestrate the development of this needed specialty. A central body is needed to organize the necessary care and ensure the right care is provided in the right setting. The trend to keeping patients in their homes requires that all levels of community care are organized.

If this kind of concentration and organization were achieved, it would be less difficult to recruit the gerontologists and other specialists needed for this field.

The hospitals also appear to ignore other changes occurring in the dynamics of health care across North America: the push for less institutionalization, the changing roles of specialties and family practitioners, public and consumer demands for accountability, the tightening grip on funding.

In its report, *Future Directions for Health Care in Saskatchewan,* the Saskatchewan Commission on Directions in Health Care outlined specific roles for Saskatoon and Regina hospitals: they should be base hospitals providing specialized expertise and tertiary and quaternary services for the entire province, as well as basic and secondary hospitals for the cities and their environs.

The three base hospitals in each city "must articulate a unified and complementary mandate which clearly defines areas of medical and administrative expertise and co-ordination," the Commission said, moving towards the concept of a "Hospital Complex". They must offer diagnosis and treatment which smaller hospitals cannot realistically provide, and share their expertise and services with those hospitals.

Ambulatory surgery

Saskatoon's hospitals have not planned strategically for surgery performed in an ambulatory setting, that is, with patients who are not admitted to hospital. Only 28% of surgery is performed this way; this compares poorly with other hospitals in Canada and North America which are reaching as high as 40-50% of all surgical procedures, with as many as 60-70% of them carried out under general anesthesia.

The study panel estimates conservatively that if Saskatoon raised the current 19,145 cases of ambulatory surgery a year to 24,579 cases, it would free 10,656 bed-days or a minimum of 29 beds, which could be allocated to services such as geriatrics or psychiatry. (See Appendix E, Table 7.)

RUH has 29 hostel beds with an occupancy rate of 49%. These beds are underused and could be expanded to accommodate patients receiving services on an ambulatory basis, such as day surgery, same-day admission for surgery, diagnostic workups and pre-admission testing.

Occupancy rates

The need for careful planning shows up here too, as some beds empty and others fill up. The trend of decreased admissions for maternity and pediatric and the movement to ambulatory surgery for specific services are causing severe dips in occupancy rates and an increase in vacant beds. At the same time, some services are experiencing high utilization and are in great need of beds.

SELECTED OCCUPANCY RATES IN SASKATOON HOSPITALS

	Low Occupancy		High Occupancy	
SCH	Obstetrics	45%	Psychiatry	97%
	Pediatrics	53.1%		
	Long-term care	49.1%		
	Ophthalmology	42.9%		
	Otolaryngology	28.2%		
SPH	Pediatrics	56.6%	General Medicine	92.6%
RUH	Gynecology	39.9%	Neonatal intensive care unit	93%
	Otolaryngology	31.7%	Pediatrics intensive care unit	95.8%
			Geriatrics	98.7%
			Psychiatry	97.3%

In a survey of occupancy rates on May 1, 1990, the overall rate for the three hospitals was 77.8%, which means that, at a minimum, 212 of the

1,406 beds in the city were empty. When SCH construction is completed, another 104 beds will be added. (See Appendix E, Table 2)

Hospital stays

Looking at preoperative days, it appears that 36% of all surgical cases in Saskatoon have three days or more in hospital before the patient has surgery. This is just one example of questionable use of the hospital, and illustrates how a same-day surgery program or a pre-admission testing program could have a positive impact on lengths of stay. (See Appendix E, Table 5.)

Shared services

Surveys show that only a few non-clinical shared services programs involving all three hospitals have been attempted. They are limited to the Saskatchewan Hospital Association Group Purchasing, the Health Services Support Group Payroll Services and Interhospital Mail. There are no programs to consolidate such services as delivery, finance, management information systems, laundry, housekeeping, personnel, maintenance, laboratory biomedical engineering, medical records, materials management and printing.

Another example is the recent effort to discover whether a central food commissary for hospitals and special care homes is desirable and feasible for the city, and to examine its advantages and disadvantages. The effort was initiated by Sherbrooke Community Centre, and a task force was established in 1989 with representatives from Sherbrooke, SCH, RUH, Parkridge Centre, Home Care - Saskatoon District No. 45, Lutheran Sunset Home and Saskatoon Convalescent Home.

After gathering data on food services costs per resident day, visiting central food commissaries and meeting with potential participants in a commissary, the task force has called for a formal study of the desirability and feasibility of establishing a food commissary in Saskatoon and region. (See Appendix D.)

Each hospital has invested funds and resources in computer systems for both clinical and non-clinical support. According to the Biomedical Equipment Service Work Group, each hospital has varying degrees of support to quality-control, maintain and repair its computer equipment, according to available expertise and funds. As medical staff become more dependent on computers, downtime to wait for parts or available expertise to correct a problem affects their workflow negatively.

Computer services

Computers are changing patient care. In the past, a computer system to perform financial or operational programs could be purchased in isolation without consideration of the system purchased by other hospitals in a community. Now, as technology advances and computers are becoming an integral part of patient care, hospitals must plan for the future and ensure that their investments today will serve their patients in the future.

Computers are used to diagnose patients; computerized axial tomography (CAT) and nuclear magnetic resonance (NMR) are two examples. Computers now perform laboratory tests and transmit the results to requesters. Physicians' offices and hospitals are creating common databases so retrieval of patient information is expedited.

The vital information residing in each institution's database must be accessible to health care providers to ensure immediacy of care, end redundancy of testing and reduce the risk of under- or over-treating patients. What is needed is a computer network among hospitals that ensures a standard database and compatibility. Since confidentiality is known to be an issue, it must be built into the design to ensure that only the people who need to know have access to the information.

Creating this system demands co-ordinated planning and a commitment to use funding resources efficiently. It demands a system designed for three institutions and prepared for future interfaces with other health care providers in Saskatoon and the province.

5. Problems of the College of Medicine

The College of Medicine at the University of Saskatchewan, the only such college in the province, labors under a complex load of problems identified clearly by Kerr White in his 1989 report, *Towards a New Beginning*. Not only is its contemporary mission obscure, it has struggled throughout its lifetime with provincial governments and university administrations which do not appreciate the true costs of maintaining a first-rate, modestly-sized medical school. The increased scope of its educational responsibilities is seldom recognized; medical research is not adequately supported. It is expected to provide or help organizations recruit highly-skilled manpower to provide most of the province's tertiary care. And it has difficulties recruiting and retaining high-quality faculty in a small and somewhat isolated medical school, competing with marketplace salaries, or establishing a research milieu competitive with larger centres.

Not only is the College responsible for training physicians and so must sustain strong educational functions at both undergraduate and graduate levels (as well as continuing education for practising physicians), it must work with the hospitals to provide an appropriate spectrum of tertiary care to the people of Saskatchewan.

In the present circumstances, it is difficult to recruit clinical, nursing and other professional staff who have a specific interest in pediatric care. In terms of training physicians, the current fragmentation means there is nowhere the necessary critical mass of patients. Some subspecialties - such as pediatric nephrology, respirology, endocrinology, nutrition and clinical pharmacology - are not represented among the teaching faculty. Because so much of the present inpatient service is devoted to critically ill infants and children, and because cases are scattered among three hospitals, the broad spectrum of diagnostic and management pediatric disorders needed for students and trainees is not present.

Other problems identified to the study panel:

- The last accreditation report (and the Kerr White report) identified basic sciences as a problem at the College.
- As the only College in the province, it must have 61 one-of-a-kind specialty programs to serve community needs, fragmenting both school and staff.
- Space for teaching and research has always been underfunded.
- Only full-time faculty can be considered for Department heads, which is not flexible enough for all three hospitals.
- The hospitals could be more accommodating to students so as to provide the best educational environment possible for them to learn and provide clinical care.
- There is no medical manpower plan for the city, and "town" hospitals appear to be encouraging physicians from the College to relocate.
- Several recent reviews have noted the heavy teaching load placed on RUH and the under-use of SCH and SPH.
- There is a problem with the numbers of interns and residents at the various hospitals.
- There is no standardized approach to education, clinical practice opportunities for residents, interns, medical and nursing students.

In another North American city, a similar mixture of medical school and group of hospitals was built on objectives which could apply in Saskatoon (Brown and McCool, *op cit*, p. 229). They are:

1. Develop a prototype, unified comprehensive health care system.
2. Share responsibility for medically underserved people and the rural population.
3. Attempt to develop a more rational system of achieving quantitative and qualitative balance in the production of physicians and other health manpower.
4. Provide medical students, interns and residents with a variety of different types of practices in different types of communities.

5. Assist hospitals in the area to develop residency programs and programs of continuing medical education.

Consolidation

In several other Canadian cities with multiple hospitals, services have been consolidated and rationalized with benefits that can occur in Saskatoon too. Such consolidation and rationalization bring together in each hospital the critical mass necessary to provide the best possible service, close gaps in services, and recruit and retain the best-qualified professional staff.

In Saskatoon, they would:

- Provide state-of-the-art patient care now and into the future, close the gaps and correct the anomalies and dangerous situations that now exist, and make the city a centre for medical excellence comparable to any in Canada.

- Lessen the need for people to leave the province for specialized treatment, and strengthen its role in medical research and education.

- Enhance specialty training for health professionals, provide greater career opportunities and improve the province's ability to train and retain specialists.

- For the hospitals themselves, make movement and referral easier, improve the flow of information, increase standardization, permit integration/co-ordination of services and develop better quality control techniques.

- For the city, reduce parochialism in individual programs and facilities and cut down on undesirable competition and duplication, while better distributing both personnel and facilities.

- And for the province, ensure financial savings through economies of scale and develop a regional approach to the provision of health care, both within and outside of institutions.

Proposal for Saskatoon

It was clear to the study panel and the conjoint group, as it has been clear to all who have studied the Saskatoon hospital situation, that services must be reconfigured and consolidated among the three hospitals. Such a configuration and consolidation would answer the problems identified above.

The study panel proposed a model reconfiguring clinical services in a more rational way which would eliminate the most glaring duplication, fill in the gaps and still promise improved services all round.

In looking at examples of rationalization and integration of hospital services, it and the conjoint group agreed that the model around which the reconfiguration centred needed to be a significant clinical service, not just a minor allied role or a simple reallocation of beds by services.

With this in mind, and after reviewing all prior studies and current utilization and national trends in health care, the panel felt that the first step to consolidation would be the creation of a maternal child centre which would include all female reproductive care, a complete spectrum of pediatric care and all the related inpatient, outpatient and emergency services. This area was chosen because it features all the problems of Saskatoon hospital services: unmet needs, duplication of services, lack of a critical mass and lack of planning.

This change would create a system with one specialty hospital (maternity and child care) and two full-service (excluding obstetrics and pediatrics) acute care hospitals. It would introduce calm into the organization of health services; once maternity and pediatrics were moved, the rearrangement of services in the two acute care hospitals would have a logical flow. Each would have specialty areas and each would offer a full range of general services (with the aforementioned exceptions).

This proposal was built on previous studies in Saskatoon, and on the views of local health care practitioners that obstetrics and pediatrics services were inadequate. The study panel had observed that fragmentation of these

services among three hospitals left some clinical needs unmet - comprehensive outpatient pediatrics services is just one example - and did not provide a milieu for teaching and research.

Its review of other university programs in obstetrics/pediatrics, at places such as Vancouver, Children's Hospital in Winnipeg, the Children's Hospital of Eastern Ontario, and proposals for Halifax, demonstrated unequivocally the value of unity of service. And it saw clearly how decanting obstetrics/pediatrics from two hospitals would permit them to meet health care needs that now are largely unfilled, freeing space for a rational and effective rearrangement and concentration of hospital services.

Although the panel examined all the arrangements for hospital services in Saskatoon and prepared its model with them in mind, it had neither time nor expertise to allocate each service specifically. However, when obstetrics/pediatrics were concentrated in one site, all other services appeared to fall into place with ease.

Maternal/Child Centre

This part of the report will examine the Maternal/Child Centre model in more detail and outline the benefits it promises to mothers and children in Saskatoon and the vast area served by its hospitals. Then it will discuss the other services.

MATERNAL CHILD CENTRE

- **Centre for Obstetrics**
- **Centre for Pediatrics**
  - **Neonatal ICU**
  - **Pediatric ICU**
  - **Research**
- **Pediatric Emergency Room**

This centre would accommodate the new trends in maternity and female reproductive care and the changing needs of health services for children, from birth through adolescence.

It would be all things to all mothers/children/families. It would provide fine and friendly facilities for women with low-risk pregnancies, giving them the care, advice and education they need throughout the pregnancy, a high-quality birth experience, and the postnatal care, advice and education required. If a low-risk pregnancy turned out to have complications, the centre would have the expertise to identify those problems and deal with them.

It would be able to immediately identify and plan for high-risk pregnancies, beginning early in the pregnancy to help the women combat those risks.

This model should meet the obstetrics needs of family practitioners in Saskatoon and area, and equally allow them to admit and treat appropriate pediatrics cases. By creating a critical mass and opportunities to use their skills regularly, it would attract more specialists such as perinatologists and neonatal intensivists.

The panel believes that establishment of such a centre will eliminate the duplication of maternal and pediatrics services described earlier, and also make it possible to fill in the gaps in services. It will also enable Saskatoon to deal with the following situations, some of which are specific to the city or province, others of which are national.

- According to *The Health of Canada's Children Report,* 1989, Saskatchewan's infant mortality rates and hospitalization rates for children are the highest in the country. The infant mortality rate is particularly high for Northern Saskatchewan. A comprehensive centre devoted to obstetrics and pediatrics, both inpatient and ambulatory, could include outreach services and improved transportation to the centre for mothers and babies.

- High-risk pregnancies are increasing and women with such pregnancies often require specialized services. Saskatchewan had the highest rate of teenage births in Canada in 1989, when 46 babies

were born to every 1,000 girls age 15 to 19, said *Future Directions on Health Care in Saskatchewan.* At the other end of the spectrum, many women are delaying childbearing until they establish career and other interests, and so the fertility rate in the 30-39 age group is increasing.

- Across Canada, in-hospital treatment of children has decreased an average of 4% a year for 20 years. The decrease should continue, thanks to new technology, drugs and treatment approaches. The Maternal/Child Centre envisioned would offer a wide range of ambulatory and outpatient services based in its specialties.

- Specialized pediatrics in the next decade will focus more and more on neonatology and complex conditions. A Maternal/Child Centre can most effectively provide the specialized resources and co-ordination required to meet these needs, at what is believed to be the lowest cost.

- Collaboration with adult services is essential. Pediatric care in the fields of transplantation, renal dialysis, cardiovascular surgery and AIDS, for example, should be a specialized but integral part of adult programs. Transportation should be available to move child and family for very rare conditions to centres where there are high-quality specialized pediatric programs.

- Careful analysis and co-ordination of emergency services as they relate to children is crucial.

- Adolescents' need for sexuality and family planning counselling and treatment of sexually-transmitted diseases can be met by a Maternal/Child Centre.

- Most children with complex conditions or chronic disease can be treated by a specialized centre as outpatients, in ambulatory or outreach programs, thanks to new technological developments. But when they require specialized inpatient facilities, for cancer, trauma

or mental health perhaps, those facilities are available in the same centre.

Federal guidelines

Health and Welfare Canada's publication, *Family-Centred Maternity and Newborn Care,* sets guidelines for centres like the one the panel proposes. They should:

- Increase the potential for survival for children.
- Improve the safety and human quality of childbirth.
- Reduce inequalities in health care delivery by providing maternity care responsive to individual differences.
- Provide parents with needed educational programs.
- Provide regionalized special care units for high-risk mothers and infants requiring special, costly diagnostic and therapeutic techniques and facilities and skilled staff.
- Standardize operational definitions for vital statistic indices and expand reporting systems to include normal and high-risk pregnancy, high-risk labor and high-risk newborns, to make such information relevant for research and program development.
- Establish and/or expand communication among the health team about the health status of mother and infant.
- Provide and upgrade continuing education for health professionals through regional child/maternal education programs.

Site

As noted, the proposed Maternal/Child Centre must be located on one site, and the most practical site is Saskatoon City Hospital. Construction there is at a stage where it could be stopped and the internal space redesigned to accommodate in one centre a comprehensive family-centred maternity and newborn care program, and a child and adolescent program.

The Master Plan

The model consolidates services and creates a distribution of specialties. Each hospital has the following categories of programs:

- **One-of-a-kind programs** for which one hospital has exclusive responsibility for providing services.

- **Major programs** for which one hospital will have lead responsibility and other hospitals have basic programs.
- **Basic programs** in which the service can be available to a greater or lesser extent in all three hospitals.

The Master Plan: Royal University Hospital

Royal University Hospital will be the major tertiary and quaternary care centre. One-of-a-kind programs will be the Cardiac Care Centre, the Trauma Care Centre, the Burn Centre. The Cardiac Care Centre will provide state-of-the-art care for cardiac catheterization, rehabilitation and surgery. The Trauma Care Centre will provide comprehensive care for the multisystem victim and all the tertiary care services necessary to support life. The Burn Centre, already well-recognized, will continue its vital services to Saskatoon and Saskatchewan.

Since RUH is now the major centre for diagnostic imagery, nuclear magnetic resonance should be located there if it is approved for Saskatchewan. It could provide a 'star' diagnostic program.

RUH is also the primary hospital for medicine, surgery and psychiatry. It will play a major role in development of a comprehensive mental health program for the three hospitals and the community. As the location of the Department of Psychiatry, it will oversee and ensure development and implementation of a thoughtful and complete program that will have special units at SCH for pediatrics and adolescents and at SPH for geriatrics and adults. At RUH, the psychiatric program will enhance existing adult programs and concentrate on the community services necessary to support mental health services.

The College of Medicine will locate at RUH academic and research programs for medicine, family practice, surgery, dental, anesthesia, diagnostic imaging, pathology and laboratory, and psychiatry.

The Model: Royal University Hospital

One-of-a-kind Programs

Cardiac Care Centre
Cardiac catheterization laboratory
Cardiac rehabilitation
Cardiovascular surgery

Trauma Care Centre
Comprehensive emergency unit to manage the full spectrum of adult emergency care

Burn Centre

Nuclear Magnetic Resonance

Major Programs

Medicine

Cardiology	Gastroenterology	Immunology
Dermatology	Neurology	Hematology
Endocrinology	Respirology	Oncology
	Infectious Diseases	

Surgery

General	Plastic	Oral Surgery
Neurosurgery	Urology	

Psychiatry

Adult psychiatric trauma unit	Emergency/regional
Adult psychiatric ambulatory care	referral/assessment unit

Forensic medicine

Diagnostic Imaging

Pathology

Nuclear medicine

Basic Programs

Medicine

Nephrology
Rheumatology

Surgery

Peripheral vascular
Thoracic
Orthopedics
Otolaryngology

Gynecology

Oncology

Physical Rehabilitation

Geriatric Assessment

Centre for College of Medicine Programs

Medicine
Family Practice
Surgery
Anesthesia
Diagnostic imaging
Pathology
Psychiatry

The Master Plan: Saskatoon City Hospital

Saskatoon City Hospital will specialize in women's and children's health care and the care of the eye. It will also be the major centre for otolaryngology and gynecology. The College of Medicine will have three major programs at SCH: obstetrics/gynecology, pediatrics and ophthalmology. The hospital will bring the teaching and research environment essential to provide the unique programs required.

The Model: Saskatoon City Hospital

One-of-a-kind Programs

Obstetrics Centre
Complete range of ambulatory and inpatient prenatal and postnatal care for low-risk and high-risk deliveries.
Services include neonatal intensive and intermediate care.

Reproduction and Infertility Centre
Endocrinology Research

Pediatrics Centre
Complete range of medical, surgical and psychiatric services and programs for children

Pediatrics Medicine

Cardiology*	Neurology	Immunology
Dermatology	Respirology	Oncology
Gastroenterology	Rheumatology	Infectious Diseases
Nephrology	Hematology	

*Duplication of cardiac catheterization facilities for pediatrics patients would have to be considered in light of economic realities.

Pediatrics Surgery

General	Oral surgery	Thoracic
Neurosurgery	Plastics	Urology
	Orthopedics	

Pediatrics Psychiatry

Child/adolescent	Child psychology
Community Assessment Treatment Unit	Youth services

Emergency Room
Dedicated to pediatrics care

Ophthalmology
Complete ambulatory and inpatient service for adults and pediatrics, including cornea transplants

Major Programs

Gynecology
Complete range of ambulatory and inpatient services for female reproductive care

Otolaryngology
Complete range of ambulatory and inpatient services, adults and pediatrics

Basic Programs

Pathology Nuclear medicine* Diagnostic imaging

*Duplication of nuclear medicine facilities would have to be considered in light of economic realities.

Centre for College of Medicine Programs

Obsterics/Gynecology Pediatrics Ophthalmology

The Master Plan: St. Paul's Hospital

St. Paul's Hospital will be the adult primary and secondary care centre, excluding obstetrics and pediatrics. It will be the Centre for Nephrology with kidney transplantation and dialysis, and the centre for a dialysis team which will service the other two hospitals. Since SPH is now the major centre for nephrology, lithotripsy should be located there if it is approved for Saskatchewan. It could provide a 'star' treatment program.

SPH will be the Centre for Rehabilitation Programs for both geriatrics and physical rehabilitation. It has the opportunity to co-ordinate and provide the multifaceted, multidisciplinary program necessary to bring state-of-the-art rehabilitative care to Saskatoon as it has done with the Palliative Care Unit.

It will also be the major hospital for rheumatology, peripheral vascular surgery, orthopedic and thoracic surgery, geriatric assessment and psychiatrics for the geriatric population.

The College of Medicine will locate at SPH its centre of academic and research programs for rehabilitation medicine, physical therapy, occupational therapy and geriatric medicine.

One-of-a-kind Programs

Surgery
Kidney transplant with immunology centre
Lithotripsy centre

Medicine
Acute and chronic kidney dialysis centre
Centre for dialysis team to service other hospitals

Geriatric and Rehabilitation Centre
A complete range of diagnostic and treatment inpatient and ambulatory services

Palliative Care Centre

Physical Rehabilitation Centre
Reconstructive surgery General
Degenerative muscular and joint disease

Major Programs

Medicine
Nephrology Rheumatology

Surgery
Peripheral vascular
Orthopedics, reconstructive and joint
Thoracic - major service for oncology and emergency care

Geriatric Assessment Unit

Psychiatry
Psychogeriatrics

Basic Programs

Medicine (adult)

Cardiology	Gastroenterology	Immunology
Dermatology	Neurology	Oncology
Endocrinology	Respirology	Infectious diseases
	Hematology	

Surgery (adult)

General	Urology	Otolaryngology
Oral surgery	Dental	Plastics

Neurosurgery (stabilize and transfer to RUH)

Gynecology

Psychiatry

Adult psychiatry Ambulatory care services Adult day care

Emergency room

Adult emergency

Basic Programs

Pathology Nuclear medicine* Diagnostic imaging

*Duplication of nuclear medicine facilities would have to be considered in light of economic realities.

Centre for College of Medicine Programs

Rehabilitation medicine Geriatrics medicine

School of Physical Therapy

Chapter IV: The Process Followed

In arriving at the model described in Chapter III, the three-member panel followed a process developed at its first meeting March 15 when it established three goals:

- to create a model for hospital services.
- to get acceptance from local people that the model was good.
- to create an environment of trust and co-operation that would allow the necessary changes in governance so the model could be put in place and efficiencies achieved.

For these tasks the terms of reference were suitable and allowed wide latitude.

The panel recognized that for progress and change to occur, each stakeholder must have a committed governing body, a committed medical and nursing staff, a commitment to the community, and a commitment to high quality care and to ethical conduct and relationships.

With these characteristics, a hospital can anticipate trends and get into position to exploit new opportunities to the benefit of the community it serves and can do its work and its planning so as to prosper in both the short and long term.

The panel believed Saskatoon's three hospitals had to be leaders in ensuring the quality and affordability of health care for its citizens. They had to be configured to respond to the rapid evolution in health care systems, nationally and internationally. And they had to recognize the importance of the critical mass concept in order to raise health care standards and attract and retain qualified medical staff.

Conjoint group

To accomplish its goals, the stakeholders were asked to contribute senior members to a conjoint group which would meet with the panel each time it was in Saskatoon. The response was gratifying. Senior members included

chairmen of the hospital boards, presidents of the hospitals, chiefs of the medical staffs, the Dean and Associate Deans of the College of Medicine.

To ensure internal communication, the panel asked each stakeholder to set up a multidisciplinary liaison committee whose members had a global view of the institution. This committee would ensure communication between staff, hospital administration and the study panel if questions or concerns were raised. The study panel was particularly concerned that there be input from nurses, who are often drawn into the decision-making process only at the end.

The work plan was divided into five sessions when panel members would be in Saskatoon and would meet interested parties.

Session 1	April 16-19	Session 4	June 14-15
Session 2	May 7-10	Session 5	June 27-29
Session 3	May 21-22		

Session 1

The first session was devoted to meeting with the Board of Governors and liaison committee of each hospital. The purpose and mandate of the panel were explained, followed by a discussion of the problems in Saskatoon and a tour of each facility. The panel made clear to both boards and liaison committees that it brought no preconceived ideas or agenda to its task and would try to be rational in analysing services and their consolidation. Finally, it promised to communicate directly to the boards to eliminate the possibility of incorrect rumors.

Questions

To obtain information and support from the hospitals, the panel asked each Board of Governors and each liaison committee on April 16 to respond to three questions:

- What are the present policies and practices for the management and delivery of hospital services in Saskatoon?
- What opportunities exist to enhance the effectiveness and efficiency of future hospital care delivery systems in Saskatoon?

- What options exist for professional resources, treatment rationalization, auxiliary services and management co-ordination to reflect anticipated future demands and developments?

The following observations and ideas emerged from meetings with each hospital and the College of Medicine and were agreed to by each:

- The *status quo* is not really acceptable.
- Radical or drastic recommendations are needed in the short term to create change.
- Saskatoon hospitals do not communicate or work co-operatively to solve problems or plan a joint direction,.
- Frustration and levels of distrust have increased in recent years.
- Change would occur if the panel made recommendations that would actually deliver better health care and were not bandaid solutions.
- The College of Medicine is a major player in the hospital delivery system in Saskatoon and hospitals must work in partnership with it to attract and retain qualified medical manpower.
- The College of Medicine would make the best 'honest broker' to facilitate and implement change.

Session 2

The second session included meetings with the Minister of Health, the hospital liaison committees, the College of Medicine, the Ad Hoc Group of City Hospital Physicians, and individual physicians, plus the first meeting of the conjoint group.

During these meetings the panel continued to explore problems and possible solutions. One of the major initiatives suggested was the amalgamation of SCH and SPH with one board and one owner.

At the liaison group meetings, each hospital presented its response to the three questions asked by the panel.

Saskatoon City Hospital said the health and hospital system in the city needed changing and it was prepared to co-operate in achieving change.

Royal University Hospital's response was based on the propositions that:

- the size and distribution of the population must be matched with available resources to create a critical mass of human and technological resources to provide a more effective and responsive service.

- the clinical education setting should reflect the practitioner's eventual environment, thus a diverse patient population (normal and complicated) is required to offer the range of experiences anticipated for the practitioner.

- as services become recognized as full teaching programs, the sponsoring educational organization (University of Saskatchewan, Kelsey, etc.) becomes the focal point for direction and standards. But education programs need not be provided at one facility.

RUH proposed that obstetrics and pediatrics be merged into one unit, suggesting this would create the needed critical mass, facilitate standards of care being met and address some deficiencies of the present system. Such a plan would provide:

- 24-hour availability of anesthetists to perform epidurals.
- 24-hour availability of physicians/residents to provide on-call services.
- a state-of-the-art transport system for pediatrics.
- enhanced liaison to the community and visiting nurses to facilitate postpartum follow-up care of infant and mother at home.
- universal access to ultrasound and respiratory technology.
- establishment of infant developmental and follow-up care.
- opportunities for students and trainees to achieve the educational and research objectives.

St. Paul's Hospital's response was a compilation of independent positions of various groups within the hospital.

Otolaryngologists submitted two papers which proposed basically that each hospital maintain an adult and pediatric inpatient service. This configuration, they contended, would maintain an adequate teaching load and access to patients with otolaryngologic problems on other services.

The Chief of Surgery recommended that SPH maintain all acute care services - plastics, neurosurgery, ophthalmology, otolaryngology, orthopedics, peripheral vascular and thoracic, urology, pediatrics, general surgery and general medicine - and add psychiatric to its outpatient services. He suggested both SPH and RUH should have radiology and nuclear medicine, and SCH - now devoid of acute care services - should be the rehabilitation centre for the northern section of Saskatchewan.

The Chief of Obstetrics and Gynecology proposed consolidating obstetrics services at SPH, transferring either the RUH neonatal intensive care unit or secondary neonatal care there. Options to handle tubal ligations included transferring the woman to another hospital or, in the case of Caesarian sections, SPH could possibly reconsider its moral position. Another option was to have a low-risk unit at SPH and high-risk at RUH.

SPH also suggested that Saskatoon has too many hospital beds and needs only one full-service community hospital and one teaching/service hospital.

The College of Medicine provided an overview of its current and ongoing problems, in response to the question. The central theme was lack of funds for faculty, support staff and services, and lack of a critical mass for teaching and research. Specific reference was made to the deficit of trained professionals which faces Saskatchewan and Saskatoon, and to the fact that 60% of the College's graduates leave the province to practise elsewhere.

The panel also met with the Colleges of Nursing, Pharmacy, Dentistry, the School of Physical Therapy and the Saskatchewan Institute of Applied Science and Technology, and discussed various problems. Again the lack of

a critical mass for students to gain experience in the full spectrum of care was the focal point. Nursing indicated this was the case for pediatrics and maternity. All representatives agreed that consolidation of clinical services would provide their schools with a better opportunity for comprehensive education.

Reconfiguration

The study panel was convinced that clinical services could be reconfigured so as to eliminate the most glaring duplication, answer the unmet needs, and promise improved services all round. It developed the proposal discussed in Chapter III, reconfiguring services around the Maternal/ Child Centre model already discussed.

In examining possible locations for this Centre, recognizing that considerable capital expenditure might be required, the panel decided the obvious locale was the yet-to-be-finished facility at the SCH site. However, it did not want to lead the conjoint group in determining its location and asked it to consider alternative sites.

This position was not acceptable to the conjoint group which felt it needed to know the panel's considerations, not just about the site of the Maternal/Child Centre but about the realignment of other adult services. The panel agreed to undertake that task and present a potential realignment, noting that it was constrained by time and an incomplete knowledge of all the clinical services involved.

The panel chairman wrote to each hospital board chairman to express the panel's understanding of what had been agreed to:

"Firstly, it was agreed that the study panel will work closely with the conjoint group over the next few weeks, understanding that the liaison committees will be kept informed and involved according to the wishes of their respective institutions.
"Secondly, the review panel, through a series of meetings with the conjoint group, will put forth their best views, based on the twin issues of quality of care and the creation of the best academic environment for

educating the spectrum of health care personnel, on the realignment of clinical services among the three hospitals.
"Thirdly, the panel shall endeavor to indicate the unmet clinical needs of Saskatoon and environs and where these services might best be provided."

Session 3

The session included meetings with individuals representing ophthalmology, pathology, the College of Physicians and Surgeons and members of the SPH nursing staff.

By this time, the Maternal/Child Centre model presented to the conjoint group had become common knowledge in the medical community and was a point of discussion with all groups which met the panel.

The SPH nursing group was very receptive to the proposed model, and felt it would address some of the weaknesses in the system. Nurses and the panel discussed the following deficiencies in existing maternity and child care:

- Lack of a complete spectrum of pediatric care, both inpatient and ambulatory.
- Pediatric rehabilitation is under-served.
- Special tests for mothers-to-be are not available.
- Epidurals are not uniformly available and women in labor may have to be transferred.
- Lack of consistency in quality and content in prenatal classes.
- Lack of space at SPH; the new unit is experiencing high occupancy.
- Neonatal intensive care unit at RUH is dislocated from labor and delivery.
- Prolonged labors due to lack of standard protocol for family practitioners to consult with obstetricians.
- Transferring babies or mothers from one institution to another is traumatic to baby or mother and interrupts the episode of care.
- Lengths of hospital stay are too long and little attention and few resources have been given to community support programs.

The nurses supported the consolidation, accepting that a single Maternal/Child Centre would create new values and standards of care that would be state of the art, personal and unique for Saskatoon and the province. Their only concern was about transferability of RUH and SPH nursing staff to the new centre. They hoped that nurses would play a major role in designing it and that the implementation plan would include a thorough orientation program for lay and medical communities.

Between the sessions of the full panel, the chairman received a letter from SPH, stating:

"...*we are not prepared to accept getting out of obstetrics and delivery services, but we are prepared to accept being the maternal health centre for Saskatoon and Northern Saskatchewan.*" (Emphasis in the original.) The letter went on to say, "*Let me reiterate our commitment to merging services, operating and affiliation agreements with the other health care partners in Saskatchewan. Provided that we retain a private, Grey Nuns' ownership of our facility, philosophy and mission, we are open to negotiations and discussions on all options.*"

The letter indicated that the board chairmen, chief executive officers and chiefs of staff of SPH and SCH had met formally to discuss the concept of two separate boards integrating and co-operating to act as "*one hospital board on two sites*". This integration excluded maternal child care.

The study panel chairman telephoned the SPH chairman. Obstetrics was discussed and the SPH chairman indicated he was willing to modify his position. It was agreed that two members of the panel would meet with members of the hospital ownership, Board of Management, the hospital president and chief of medical staff to continue the discussion.

At this meeting on June 11, SPH indicated that it would be very difficult for it to give up obstetrics and support the Maternal/Child Centre model.

Compromise

After discussion, a compromise was considered. Sensitive to the hospital's concerns, the panel asked if an 'obstetrics presence' at SPH would answer those concerns. This would have limited beds (five to six was discussed) handling only Level I care, and special safeguards would ensure SPH would not develop obstetrics to a full service.

SPH was willing to accept this if the hospital could have the flexibility to respond to the needs of the community.

The integration of SPH and SCH was discussed. SPH indicated that it would continue discussion but felt that the merger would not come to fruition due to the differences in attitudes, missions and philosophies of the two institutions.

The panel, cognizant of the sensitivity of these issues, drew up a new master plan and distributed it to the hospitals before the next conjoint group meeting that was scheduled.

Session 4

The session included meetings with nurses from RUH and SCH, the work groups on psychiatry and geriatrics, and representatives of the Hospital Services Branch of the Department of Health.

These nurses, too, were supportive of the Maternal/Child Centre. Both groups unanimously agreed that the model was ideal and would improve health services and the teaching environment for nurses, residents and interns. They opposed the 'obstetrics presence' at SPH, saying it would compromise health services for mothers. Having a small satellite unit would continue to divide up care for mothers and infants of Saskatoon. There was a firm consensus to concentrate services in one unit.

Again the nurses voiced concerns about job security, transferability of seniority and benefits and the need to have nurses involved early in the design of the Centre. There seemed to be agreement that these concerns could be worked out.

Shortly before the conjoint group's second meeting on June 15, the study panel chairman had received a message from SCH which indicated that its board was continuing discussions with the SPH board on integration of the two facilities. This contradicted the informational position expressed by SPH representatives at the June 11 meeting held to discuss SPH's position on obstetrics.

The June 15 meeting examined the study panel's master plan, which had previously been circulated. First the model was studied, and then the organizational structure.

The College of Medicine supported the Maternal/Child Centre, stating that wherever the clinical services were placed, the College had to be assured that university programs would not be endangered. Any hospital with university programs would have to be committed to meet the university needs for teaching, including the provision of space for research and teaching. There was a commitment from the three institutions that the College's academic needs would be met.

SCH supported the model and indicated that there had been no disagreement when it was presented to the hospital's medical staff.

SPH presented a mixed message and had no unified position. There was acceptance of the Maternal/Child Centre as a concept, although it was felt that maternal/child care was not a priority and other unmet needs - in geriatrics and rehabilitation - needed attention. They said the proposed 'obstetrics presence' in a satellite unit at SPH with a direct link to the Maternal/Child Centre would need further consideration.

RUH felt the model would not work if obstetrics was divided between two sites. It and SCH supported the Maternal/Child Centre as the central focus of the redistribution of services in Saskatoon.

The panel chairman addressed the issue of hospital mergers raised at the last meeting. He noted that the panel had received realignment proposals from each hospital, all different.

Since there was no consensus, the panel decided it was inappropriate to consider mergers at this time. It recommended that all three hospitals remain distinct administrative entities for now, and that a co-ordinating body be established with authority to:

- Flesh out the realignment of services within the hospitals, protecting the concept of a Maternal/Child Centre at SCH.
- Ensure the development and implementation of the model, and monitor its progress.

After considerable discussion, it was agreed that Saskatoon hospitals were closer than they had ever been to agreement on realignment of services, and that the model proposed by the panel deserved to be developed further and instituted rapidly and thoughtfully.

Two options for achieving this were considered, both involving the Dean of Medicine to ensure the College's needs were met.

Option I

- Establish a small committee with representatives from the College and the hospitals, chaired by an outside facilitator.
- Hospitals and university empower their representatives to finalize all aspects of the model, including sites of clinical services, and identify appropriate resources at each site to meet clinical, teaching and research needs.
- Establish a process to institute, co-ordinate and monitor the realignment of services and academic resources.
- Set a realistic time frame for realignment.
- Work with the Department of Health to determine capital and operating cost implications.

Option II

- The Department of Health establish a co-ordinating body with authority to direct the hospitals in refining and implementing the model.

The panel asked all parties to consider these options and give it their reaction before the next conjoint group meeting, set for June 27.

When the panel convened its fifth session that afternoon, it expected to meet with various groups to further refine the model and discuss the hospital boards' responses to the governance options developed on June 15.

Chapter V. Conclusion and Recommendations

The consensus for consolidation and the concomitant rearrangements of services at the three hospitals collapsed at the meeting of the conjoint group on June 27.

Panel members flew into Saskatoon for three days of meetings thinking that all that was left to do was work out with the committee plans to put the model into effect. Instead, the proposals which had been gaining acceptance were rejected categorically in a letter from the board of SPH received by the panel just minutes in advance of the June 27th meeting and read to it by the panel chairman.

The letter quoted a motion passed by the hospital board:

"That St. Paul's Hospital reject the proposed model that there be a Maternal and Child Health Centre for Saskatoon and Northern Saskatchewan, and do not agree that it is required or warranted for a community of our size; and that St. Paul's Hospital reaffirms our position that we are not prepared to give up our role in obstetrics and birthing, and we agree to be the centre for obstetrical services as outlined in our letter of May 29, 1990; and further that St. Paul's Hospital is prepared to work with another hospital in the delivery of obstetrical services if this is appropriate."

SPH representatives gave the panel a second letter disputing the minutes of a conjoint group meeting which referred to SPH acceptance of the model of a Maternal/Child Centre. It denied that SPH had agreed to the model or that any obstetrical service which continued at SPH would be a satellite service to the Centre.

The panel watched in dismay as the fragile consensus collapsed. The SPH letter was the deathknell for further deliberations. After hearing it, the other stakeholders showed they had no commitment to the model which all had previously supported. What SPH offered was unacceptable to the other

hospitals. RUH still supported the model but wanted a different governance system; that too proved unacceptable. SCH had accepted the Maternal/ Child Centre model but was now unsure of the best location for it. It proposed discussion of a different configuration of other services, and its suggestions resembled what was proposed in the 1989 Centres of Excellence discussion.

The hour of discussion which followed revealed to the panel the acrimony and depth of distrust among the stakeholders. It made very clear the hopelessness of persuading them to look past their own selfish interests and seize the opportunity they were offered to design their own future.

> *"But in life, in certain types of life, you can have a situation where a player has such grotesque fantasies about another one that he ends up by inventing the enemy he needs."*
>
> John le Carre: *The Russia House*

As already stated, to achieve progress and positive change, a hospital must have a committed governing body, a committed medical staff, a commitment to the community and a commitment to high-quality care and to ethical conduct and relationships. Those commitments are three times as necessary when three hospitals are involved. The panel heard lip service to these ideals but true commitment was lacking. Despite an apparent consensus that the *status quo* could not continue, in the end the hospitals decided to stay with the comfort of the *status quo*.

> *"Because by doing nothing we change nothing. And by changing nothing we hang on to what we understand, even if it is the bars of our own gaol."*
>
> John le Carre: *The Russia House*

The panel believes the hospital boards may find themselves lonely in their position. There is among the public and many health care practitioners in Saskatoon an awareness of the problems and inefficiencies of the present arrangement of hospital services, and a desire for change. There is enough

desire for change and enough good will for external forces to make something happen - enough that the government need not despair.

The panel was very cognizant of and sensitive to the particular mission of SPH and made every effort to react positively to that mission in order to ensure the hospital's continued ownership and dedication to its mission. However the role and mission of no single institution should override the needs of the citizens of Saskatoon, nor should they be destructive to the development of adequate clinical care in a supportive environment for academia.

As already stated, the panel had three goals for its work in Saskatoon:

- to create a model for hospital services.
- to get some acceptance from local people that the model was good.
- to create an environment of trust and co-operation that would allow the necessary changes in governance so the model could be put in place and efficiencies achieved.

It succeeded in the first two goals, but failed in the third. The effort fell apart not because the idea is bad, but because the stakeholders don't trust each other. They remain victims of what was described to the study panel as "The Saskatoon Disease" with two main symptons: blind loyalty to one institution and constant disparagement of the other two.

After reconsidering, panel members still believe the model described is the most appropriate realignment of resources. It believes the development of a Maternal/Child Centre will do more to address unmet clinical and academic needs for Saskatoon and Saskatchewan than any other realignment it can conceive of at this time.

The panel is grateful to RUH for putting forward another option. It considered that option, as well as alternative realignments, but continues to feel that the Maternal/Child Centre model is the ideal, that it would meet Saskatoon's needs and bring it national leadership in the provision of child care.

First and foremost, however, the panel remains convinced that consolidation and co-ordination are vital for Saskatoon's hospitals. Therefore, it recommends:

1. **The ideal of a unified, consolidated and co-ordinated Saskatoon Hospital Complex must immediately become a reality to ensure that comprehensive medical services are available in the future, that planning and development of programs and services reflect the profound changes occurring in needs and circumstances and that the most effective and efficient use of personnel, technological and financial resources is made.**

   (a) All clinical services must be rationalized to ensure the best possible delivery of secondary, tertiary and quaternary care with a minimum of duplication.

   (b) A co-ordinated plan must be produced to designate certain hospitals as having particular responsibility for developing the new programs and services required to meet the needs of the people in this area.

   (c) A system must be developed to link and co-ordinate a number of technical and support services which will increase co-operation and reduce competitiveness.

2. **A specific model for rationalizing medical services into centres of specialization must be developed and a plan for implementing the model adopted, to ensure that a full range of medical services is available, that Saskatoon maintains its status as a leading Canadian medical centre, that the facilities in place serve the most pressing and legitimate medical needs and that openness and vitality are introduced to ensure continued innovation and progress.**

(a) Each hospital must have primary responsibility for a designated set of services and share responsibility with another facility for other services

(b) Needs which are currently unmet must be addressed by new initiatives in order to keep pace with the most significant changing expectations and circumstances:

(1) All obstetrical and pediatric care should be located in a new Maternal/Child Centre.
(2) Geriatric services must be consolidated in one centre to increase their comprehensiveness and ensure medical specialists are available.
(3) Rehabilitative medicine must be developed in a systematic and orderly way in one centre.
(4) Services to the mentally ill must be dramatically increased and co-ordinated among the three centres.

(c) Programs at each hospital should be categorized as:

(1) One of a kind: services available in centres of specialization in only one hospital.
(2) Major: services usually available in two hospitals, one of which has the lead responsibility.
(3) Basic: services which could be available to a greater or lesser extent in all three hospitals.

(For a complete model for each hospital, see Chapter III, pages 35-42.)

3. The three hospitals must undertake joint ventures, develop uniform information-gathering and storing systems, create systems for sharing personnel resources, and enhance the potential of support service centres in order to minimize duplication, improve linkages for

information sharing, increase effectiveness in utilizing staff resources and develop alternatives to hospitalization.

(a) Consideration must be given to creating a common hospital strategy for recruiting and placing personnel, particularly the possible sharing of professional services, especially nurses, therapists and technicians.

(b) Consideration must be given to establishment of a child-care centre which will serve the staffs of all three hospitals in a way that provides for variations in staffing requirements over a 24-hour period among professional staff largely comprised of women.

(c) Consistency and uniformity must be established in the hospital information systems to permit exchange of patient information as needed to expedite adequate and rapid treatment response, and to establish linkages for the purpose of research and indepth analysis.

(d) Consideration must be given to establishing hostel facilities which serve all three Saskatoon hospitals because their clients include many patients who travel long distances and may require some monitoring of their condition before and after hospitalization but who do not need continuing inpatient treatment.

(e) Consideration must be given to establishing a food commissary responsible for food services to the hospitals and possibly to other institutions in Saskatoon.

(f) Consideration must be given to increased consolidation and centralization of such services as laundry, housekeeping, maintenance, printing and materials management.

The panel is deeply concerned about the inability of Saskatoon and the College of Medicine to attract and retain the physicians required to continue to meet teaching and training needs and provide physicians with the skills that will be required by Saskatchewan in future. Indeed, should the present environment continue, the panel has grave concerns about the College's ability to maintain continued accreditation of its academic program. Its viability may be threatened. The panel warns that some accreditation body may recommend its dissolution.

If this province wants to have a College of Medicine, Saskatoon must react to the needs of that College.

Therefore, the study panel recommends:

4. **A partnership must be quickly developed between the College of Medicine and the Saskatoon hospitals which will place the hospitals on a "level playing field" in their teaching and research responsibilities, as determined by the area of specialization located in each, and ensure an ongoing academic component for each area of specialization.**

   (a) A formal agreement must be signed between the College of Medicine and each hospital which defines the teaching and research responsibilities for the hospital's area of specialization and is consistent in its provisions in every case.

   (b) The physician specialist who heads each area of exclusive specialization in a hospital will have dual responsibilities as chief of the hospital department and chairman of the academic program in the College of Medicine.

   (c) The role of department chairman for each area of specialization must be consistently defined by all three hospitals.

(d) A clearly-defined process must be established in the Saskatoon hospital system for the selection of department heads, through establishment of a selection committee with a representative of the hospital board in which the area of specialization is located, the Dean of Medicine or his/her designate, a representative of the medical staff within the department and a representative of the nurses practising in the specialty area.

The panel is gravely concerned about the ability of a small group of stakeholders to negatively influence the delivery of adequate, appropriate, cost-effective care to this city of approximately 185,000 and the region it serves - including the whole of Northern Saskatchewan.

The three hospitals have, for too long, focused on their own self-interests. They have not addressed the clinical needs of Saskatoon and the large area of Saskatchewan they serve nor have they been concerned with the academic needs of the College of Medicine. Such positions will not serve to place Saskatchewan in the forefront of contemporary medicine. The hospital boards must recognize that there are other players besides their medical staffs to whom they must lend an ear.

Therefore, the study panel recommends:

5. To ensure that the rationalization and consolidation of all clinical and non-clinical services among Saskatoon hospitals becomes a reality, to establish a basis for systematic and co-ordinated planning and to introduce an innovative and outcomes-oriented system, the government of Saskatchewan must establish a Saskatoon Hospital Services Authority with full responsibility for determining priorities, defining services and allocating funding.

(a) The Authority should have 9 members:

(1) a senior representative of each of the Ministers of health and education, other than deputy ministers.

(2) a senior representative of the President of the University of Saskatchewan, outside of the College of Medicine.

(3) six members of the community at large selected by a special nominating committee with one representative of each of the Saskatchewan Registered Nurses' Association, the College of Physicians and Surgeons and the Saskatchewan Health-Care Association. These community members should exclude members of existing hospital boards and administrations, active and associate medical staffs and employees of the three hospitals.

(b) Members of the Authority should serve three-year terms, with the possibility of a second term.

(c) The Authority should hold an organizational meeting at the beginning of each year and select a chairperson from among the "at large" representatives among its membership.

(d) The Authority should develop a management team with the appropriate knowledge and expertise to carry out its mandate and should establish advisory committees involving health care professionals in the various fields.

(e) In choosing a chief executive officer, the Authority should look beyond the current staffs of the three Saskatoon hospitals and the College of Medicine.

(f) The ownership and ongoing management of the hospitals would remain unchanged, however their boards would function in

accordance with policies and directions determined by the Authority.

The concept of ownership should be considered in light of today's fiscal realities, the panel believes. The bulk of capital costs and all of the operating costs for hospitals flow through the Department of Health and originate from tax dollars. As a result, ownership now evolves to a great extent to the users of the services as well as the providers.

The panel has been impressed with the tolerance and patience of the Saskatchewan Department of Health. Considerable time and effort have gone into review and study of the allocation of acute care hospital services in Saskatoon, to no avail. In light of this, the panel recommends:

6. **To make efficient and appropriate use of acute care facilities in Saskatoon and lay a foundation for the most effective future delivery of health care, the government of Saskatchewan must commit itself to an action plan which would bring about a high degree of rationalization and consolidation of clinical and non-clinical hospital services to meet the best interests of the people of Saskatchewan.**

   (a) The government of Saskatchewan must pass legislation to ensure that the changes which are considered essential are implemented, particularly the establishment of a Saskatoon Hospital Services Authority.

   (b) To ensure that current actions, plans and activities don't result in further obstacles to rationalization and consolidation, the government of Saskatchewan must adopt an interim implementation strategy, which could include the appointment of an independent three-member advisory commission to the Minister of Health until the legislation has been enacted.

(c) The minister's advisory commission must assume specific responsibility for ensuring that the construction at Saskatoon City Hospital aligns with the consolidation of services proposed; that a functional program is developed in consultation with the hospital board and administration, physicians and nurses; and that the appropriate modification of the plans occurs in keeping with the redefined mandate for the hospital.

Their experience in Saskatoon has left the members of the study panel with the view that the delivery of health care in Saskatchewan is not based on solid and selfless planning and that this situation, if allowed to continue, will not serve the public well.

Panel members believe that health care is more than a political matter. Decisions on its delivery must be made on the basis of quality with the goal of meeting the true needs of the citizens of Saskatchewan, bearing in mind the cost of health care and the need to provide cost-effective care.

Health care should not be viewed on the basis of votes - but on quality and need. The province of Saskatchewan, which introduced both hospital insurance and Medicare to the nation, should remember that. It must return to it, so it can react appropriately to the rapidly changing forum of health care and once again become a leader and innovator in the provision of health services.

Acknowledgements

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- The approximately 150 people who met with the panel to voice their views and concerns and make suggestions, particularly Local 75, Saskatchewan Union of Nurses, the various nursing groups, the College of Physicians and Surgeons of Saskatchewan, the Geriatric/Rehabilitation Task Group and the Psychiatric Work Group.
- Those who made personal communications to panel members.
- The members of the Saskatchewan Commission on Directions in Health Care, particularly chairman Dr. Robert Murray and deputy chairman Walter Podiluk.

All these communications added to the breadth of information received by the panel and allowed it to arrive at its conclusion. Despite the outcome, the people who met the panel were unfailingly polite and co-operative, and panel members appreciate that.

APPENDIX A: THE STAKEHOLDERS

1. ROYAL UNIVERSITY HOSPITAL

Background

Opened 1955 on the University of Saskatchewan campus, Crown-owned major tertiary care centre governed by special act of the Legislature. Affiliation agreement with College of Medicine. Board of Governors includes Dean; others appointed by government. Most recent addition completed May 1988, $24 million; now conducting functional space/program review.

Mission

"The mission of University Hospital is to provide exemplary patient care in an academic environment which fosters enlightened teaching and scholarly research. Within this unique environment, the members of the hospital community dedicate themselves to providing compassionate, skilled care to meet the various needs of each person seeking help.

"By example, instruction and keeping abreast of new knowledge, the members of the hospital community will ensure the best education possible for the future health-care professionals, so that the traditions of providing quality health care for Saskatchewan citizens can be continued and improved.

"The members of this hospital community are committed to research not as an end in itself but because research is essential to correct the shortcomings of present-day practice, to improve the methods of delivering effective and efficient health care, and to find better ways of relieving pain, disability and disease.

"What distinguishes University Hospital from other hospitals in the province is the primacy of the functions of teaching and research."

The hospital's philosophy focuses on commitment to patients, to each other, to the community, and to tolerance and mutual respect.

Budget

1989-90 Hospital Services Branch payments $95.3 million, highest in the province, representing about 16% of provincial hospital funds.

Clinical Summary

Provides roughly 100 tertiary care services to the northern half of Saskatchewan, 60 to the entire province; the traditional programs, and ambulatory care, home care, outreach clinic, rehabilitation and burn unit.

Fifty per cent of discharges are for musculoskeletal diseases, pregnancy and childbirth, diseases of the circulatory, digestive and nervous systems. More than half the discharges are managed by five subspecialties: obstetricians/gynecologists 20%, pediatricians 18%, general surgeons 11%, orthopedic surgeons 10%, cardiologists 8%.

As of May 1,1990: 595 bed complement — Occupancy rate 78.9%
600 beds set up
470 beds in use

Average length of stay for inpatient discharges, 8.7 days.
Number of inpatients and outpatients in year ending March 31, 1990: 894,494 (nearly 78% of the volume of the three hospitals.)
Number of diagnostic services provided in year ending March 31, 1990: 12,160,186. (See Appendix E, Table 1.)

More than 69% of patients live outside the Saskatoon region. Natives make up 9% of all discharges, the highest proportion in the three hospitals.

Staff

Active and associate physicians	276
Total medical/non-medical staff	2,239

Students

Has 804 students, including 240 medical students, 142 interns and residents, 236 students in the College of Nursing, and 15 other professions.

2. SASKATOON CITY HOSPITAL

Background

Began in 1906 as the Saskatoon Municipal Hospital, established on its present site north of downtown in 1909. Board appointed by the council of the city of Saskatoon. In the midst of building a new 488-bed $122-million facility; occupancy planned for 1993.

Mission

"The mission of Saskatoon City Hospital is to provide a comprehensive range of high quality inpatient and ambulatory acute care services in an effective, caring and economic manner which reflects the current state of development of health care, for the community of Saskatoon and district and as a major referral centre for central and Northern Saskatchewan; and to participate in, support and encourage teaching and research efforts in the medical and allied health care fields."

Budget

1989-90 Hospital Services Branch payments $37 million.

Clinical Summary

Services include such specialized areas as surgery, medicine, obstetrics, pediatrics, gynecology, psychiatry, orthopedics, urology, otolaryngology, ophthalmology, neurosurgery and plastic surgery, excluding the subspecialties of renal dialysis, major transplantation and cardiac surgery.

Diseases of the digestive system, pregnancy and childbirth, otolaryngology, musculoskeletal and female reproductive system account for just over 50% of inpatient admissions. Majority of inpatient admissions seen by the following: family practitioners 33%, general surgeons 16%, obstetricians 11%, otolaryngology 10%, orthopedic surgeons 9%.

As of May 1, 1990: 384 bed complement — Occupancy rate 75%
379 beds set up
288 beds in use

Average length of stay for inpatient discharges, 7.1 days.

Number of inpatients and outpatients in year ending March 31, 1990: 127,100.
Number of diagnostic services provided in year ending March 31, 1990: 2,749,100. (See Appendix E, Table 1.)

Fifty-two per cent of patients live in Saskatoon, the rest in communities in central and Northern Saskatchewan. Natives make up 5% of discharges.

Staff

Active or associate physicians	202
Total medical/non-medical staff	853

Students

Trains more than 700 health professionals in 14 disciplines each year. Now fully accredited as a teaching hospital after being put on probation in 1988 by the Federation of Medical Licensing of Canada, which accredits internship programs. A survey team was critical of the mixture of work and education, found deficiencies in the system of evaluating interns, and ordered the administration to arrange an affiliation agreement with the College of Medicine, which has been done.

3. ST. PAUL'S HOSPITAL

Background

Opened 1907 and operated on the west side of Saskatoon by the Sisters of Charity (Grey Nuns) of Edmonton. Local Board of Management appointed by the Corporation of the Grey Nuns consists of sisters, private citizens and representatives of public bodies. Just completed $52.7-million expansion which provides new emergency, outpatient, operating room, diagnostic imaging, and labor and delivery facilities. Developing an affiliation agreement with the College of Medicine.

Mission

"We, the Grey Nuns, Board of Management, administration, employees, physicians and volunteer workers of St. Paul's Hospital believe that we form a healing community providing health care with a difference. We understand this to be our mission.

"The uniqueness that characterizes St. Paul's Hospital and the care that we provide arises out of a true understanding of and commitment to compassion and charity. Compassion and charity mean that we believe in and are guided by Jesus' words, 'As long as you did it for one of these, my brethren, you did it for me' (Matthew 25:40).

"In this mission, we are committed to providing a spiritual and loving atmosphere which is conducive to the alleviation of pain and suffering of others, be they patients, families or staff. We believe in celebrating life by promoting health of the body, mind and soul of our patients as we relieve pain. This dedication is rooted in our awareness of the inner spirit so apparent in Marguerite d'Youville, foundress of the Grey Nuns, and the sisters and staff who have given life to St. Paul's over so many years."

Principles of care are in categories for a church-related hospital, a community hospital and a base and teaching hospital. SPH principles as a Christian and Roman Catholic institution require it to provide health care which considers the whole person - body, mind and soul - and give first consideration to patients' welfare, regardless of race or religion. It strives to be a Christian model of the delivery of compassionate and quality health care, and to deliver pastoral care for patients and families. As a Catholic hospital, SPH provides health care which "respects the

mystery of life from the time of conception to its natural end". This prevents it from providing sterilization or *in vitro* fertilization.

Budget

1989-90 Hospital Services Branch payments $42.9 million.

Clinical Summary

General hospital services in virtually all areas of clinical medicine except psychiatry, geriatrics, neurosurgery, burn care, rehabilitation medicine. Central hospital for renal care, vascular laboratory and the newly-opened palliative care unit.

Pregnancy and childbirth, diseases of the digestive system, musculoskeletal, otolaryngology and female reproductive system account for 50% of discharges. Forty per cent of discharges are managed by family practitioners, followed by general surgeons 13%, obstetrician/ gynecologists 12%, orthopedic surgeons 7%, otolaryngology 6%.

As of May 1, 1990: 427 bed complement Occupancy rate 78.6%
399 beds set up
336 beds in use

Average length of stay for inpatient discharges 6.2 days.
Number of inpatients and outpatients in year ending March 31, 1990: 137,737
Number of diagnostic services provided in year ending Marc h 31, 1990: 3,566,815. (See Appendix E, Table 1.)

Most Saskatoon-oriented, with 60% of discharges originating from the city's population. Native population makes up 7% of discharges.

Staff

Active and associate physicians, 195
Total medical/non-medical staff 1,140

Students

Trains more than 500 students, including interns and residents, nurses, and students in other health professions.

4. COLLEGE OF MEDICINE, UNIVERSITY OF SASKATCHEWAN

Background

Created to train and retain the physicians and specialists needed to improve Saskatchewan's health care system and its people's health. Took its present form in 1953 when a four-year M.D. program began, climaxing four decades of groundwork started in 1911 when the city of Saskatoon agreed to build University Hospital; the School of Medical Science was established in 1926. The idea of a College was endorsed in the 1944 Sigerist report. University Hospital became fully operational in 1956 and the first class of physicians graduated in 1957.

In 1965 a physiotherapy in rehabilitation medicine program began; in 1972 Royal College specialty programs were transferred to the University. In 1976 a School of Physical Therapy was added. In 1974 full-time faculty were added in Regina but those offices were cut back in size in 1987. A new undergraduate curriculum was introduced two years ago, and affiliation prelicensure training for interns this year.

Budget

$50 million in 1989-90 from the Department of Education through the University, the Department of Health, and external funding sources. It receives no funding from the RUH budget. Funding earmarked as follows: $13 million to $14 million for university programs, $9.5 million for research, $12.3 million for clinical services, $12 million for clinical earnings, $1.9 million for community health and epidemiology.

In his 1989 report on the College, T*owards A New Beginning*, Dr. Kerr White recommended additional annual expenditures of about $9.7 million and a one-time capital expenditure of $2.3 million to start a training program for occupational therapists.

Mission

Described in 1953 by Dean J. Wendell Macleod as:

1. The provision of sound basic education for the doctors, nurses and other members of the health team required in this part of the Canadian Middle West.

2. The arranging of suitable continuing training throughout the professional lifetime of each member of these groups.
3. The constant evaluation of the health needs of the people of the province and the gearing of undergraduate and postgraduate education and training to promote health and to provide the best possible medical care.
4. The fostering of appropriate research in the basic medical sciences, in the clinical academic fields and in those aspects of the social sciences pertaining to medical care.

However, in 1989 the Kerr White report said ". . . one of the major problems facing the College of Medicine is the lack of a clear sense of purpose or mission". It suggested that a College in a province of one million "must be an integral part of that province's health care system in order to avoid unnecessary duplication, to respond to unmet needs, and to use limited resources effectively".

The first of that report's 34 recommendations called for development of a mission statement recognizing that:

1. The College's primary responsibility is to ensure that future generations receive the best possible health care and so its predominant mission is to provide first-rate university education for the preparation of physicians (including those who will become practitioners, teachers, investigators and administrators), physical therapists and other health care professionals to serve the health needs of Saskatchewan people.

2. The College of Medicine is an integral part of Saskatchewan's health care system and must help provide human and intellectual resources to fulfil the general mission of that system so that Saskatchewan people have a universally accessible, cost-effective, scientifically justified, comprehensive, compassionate and balanced health care system.

Programs

Teaching undergraduate:

Two years pre-med, four years medicine

Class size 60. College size 240.

Teaching postgraduate clinical: 19 specialty programs

Anesthesia, cardiology, general surgery, geriatric medicine, internal medicine, respiratory, rheumatology, medical imaging, nuclear medicine, neurology, neurosurgery, obstetrics/gynecology, opthalmology, orthopedic surgery, pathology, pediatrics, plastic surgery, psychiatry, rehabilitation medicine.

211 interns and residents

Affiliation

The College has affiliation agreements with RUH and SCH for residencies. There is no institutional agreement with SPH, however the College has agreements with individual physicians practising at SPH.

Rotating residency programs

RUH: Anesthesia, family medicine, general surgery, internal medicine, orthopedic surgery.

Graduate students in basic sciences: 40

School of Physical Therapy: 30 students per year

Faculty

Full-time	236	Clinical practice plan	137.5
		Clinical services fund	33
		Basic scientists	51
		Other	14.5
Part-time	579		
Total	815	(includes 97 family medicine preceptors)	

APPENDIX B : EXAMPLES OF CONSOLIDATION IN CANADA

Victoria, B.C.

The city's major acute care hospitals - the publicly-owned Royal Jubilee with such specialty services as a cancer clinic, a renal dialysis unit, a cardiovascular unit, psychiatry and neurosurgery, and Victoria General, formerly St. Joseph's, a general hospital with a reputation for high-quality care - were amalgamated in 1983 by the provincial government. It installed a public administrator for the purpose.

The Royal Jubilee had had administrative problems in the decade preceding amalgamation. The Victoria General had moved into a new facility far from its usual patients, who then crowded the Royal Jubilee. There was destructive competition between the hospitals and unnecessary duplication; cost control and efficiency were poor at a time of government concern about rising health costs; and a battle about abortion was ongoing.

Post-amalgamation, the hospitals are communicating and there is less parochialism. The abortion issue no longer impedes their operation. The board and administration are stronger, and there has been movement toward amalgamation of medical staffs. Hospital finances have been brought under control, and programs improved. Savings from reduced administration have been reallocated to patient care.

Hamilton, Ontario

In 1979, the Chedoke-McMaster Hospitals were created by merging campus-based McMaster University Medical Centre with Chedoke Hospital, primarily community-based with a small acute care facility but with significant rehabilitation, geriatric assessment, and child and family psycho-social services. They now have one board, one administration and one medical staff, although two geographic divisions have been maintained.

The amalgamation benefited Chedoke's acute care and diagnosis and enriched McMaster University Medical Centre with programs such as rehabilitation, handicapped children's services, and psychosocial and alcoholism treatment, all rare at teaching hospitals.

Regina, Saskatchewan

The South Saskatchewan Hospital Centre was created by the Saskatchewan Legislature in 1967 to improve co-ordination among Regina's hospitals, create a tertiary centre in the southern half of the province, and be the teaching arm of the College of Medicine, University of Saskatchewan. The Centre incorporated Wascana Hospital, a chronic disease and rehabilitation facility; the acute-care Pasqua Hospital (originally the Grey Nuns); and the new Plains Hospital, which was to be a teaching facility.

After extensive planning and discussion, services in the city were allocated among the various SSHC components and the acute-care Regina General Hospital. Services such as laboratories, library, laundry and food services were centralized. After Wascana Hospital left the Centre, many shared services agreements had to be negotiated, and the Regina system is still evolving.

Toronto, Ontario

The Queen Elizabeth Hospital/Toronto General Hospital Conjoint Geriatrics Services is an example of an arrangement between institutions designed specifically for joint operation of a specialized program.

Begun in 1984, this program has three aims: to be a model of optimal care to acute and/or chronically ill elderly patients, to teach professional groups about geriatric medicine, and to conduct and encourage research into disorders among the elderly. The hospitals appointed a joint medical head for the program, and each hospital offers its expertise in such areas as high technology monitoring and multidisciplinary team assessment; they share teaching and research opportunities.

APPENDIX C: THE MATERNAL CHILD CENTRE

Family-Centred Maternity and Newborn Care, a publication by Health and Welfare Canada, describes such centres, their organization and goals.

Guidelines

Such centres should:

- Increase the potential for survival for children.
- Improve the safety and human quality of childbirth
- Reduce inequalities in health care delivery by providing maternity care responsive to individual differences.
- Provide parents with needed educational programs.
- Provide regionalized special care units for high-risk mothers and infants requiring special, costly diagnostic and therapeutic techniques and facilities and skilled staff.
- Standardize operational definitions for vital statistic indices and expand reporting systems to include normal and high-risk pregnancy, high-risk labor and high-risk newborns, to make such information relevant for research and program development.
- Establish and/or expand communication among the health team about the health status of mother and infant.
- Provide and upgrade continuing education for health professionals through regional child/maternal education programs.

The Perinatal Care Network

The national guidelines describe six phases of reproductive care requiring assessment and management: preconceptual, antepartum, intrapartum, postpartum, neonatal, and developmental outcome. They suggest that each community or region develop a co-ordinated perinatal care network to meet these needs efficiently and and cost-effectively, ensuring comprehensive and continuous care is there when it's required.

Level 1

These perinatal care units are the obstetrical/neonatal facilities and services provided in one hospital for the benefit of mothers and newborns with no significant identifiable risk. Resources must be available to provide care in emergencies which cannot be anticipated, including

maternal and neonatal stabilization and neonatal resuscitation prior to transport. These facilities should be adjacent to the birth room.

Level 2

Located in major acute care hospitals, these units offer Level 1 facilities and services and also have resources for mothers and newborns with such high-risk problems as premature labor at 32 or 34 or more weeks gestation and suspected neonatal sepsis. They will develop policies and procedures with assistance from professional bodies representing family physicians, pediatricians, obstetricians and gynecologists, nurses, etc.

Level 3 - The Maternal Child Centre Proposed for Saskatoon

Such a regional centre will offer Level 1 and 2 care for its local population and be a central referral unit for high-risk perinatal problems requiring more specialized professional expertise. It will also:

- co-ordinate data collection and evaluation of services for the region through a perinatal outreach program;
- provide collaborative assistance in introducing new approaches to perinatal care throughout the region;
- provide primary and continuing educational programs;
- provide quality assurance guidelines and conduct research into causes, prevention and treatment of various diseases associated with reproduction.

The Level 3 perinatal care unit has the resources to manage mother and newborn with a wide variety of dangerous problems and difficulties. It could offer state-of-the-art care for Northern Saskatchewan with its many high-risk mothers and babies.

The national guidelines stress that regionalization does not mean centralization. Regional perinatal concepts "*involve a fine balance between a critical mass of sufficient deliveries to provide a high level of expertise (so that the perinatal team is able to deal with rare but catastrophic events) and local considerations and parental desires for a high level of intimacy and personalized care in a familiar setting.*" (Page 18)

ESSENTIAL COMPONENTS OF THE MATERNAL CHILD CENTRE

CLINICAL SERVICES	ambulatory	preconceptional
		antepartum
	hospital	antepartum
		intrapartum
		intrapartum intensive care
		postpartum
		neonatal intensive and intermediate care
		neonatal convalescent care
		well-baby nursery
	transfer program	communications
		transport (maternal-fetal and neonatal)
	administration	program evaluation
		documentation
		statistics
		quality assurance and quality control
	education	perinatal
		inservice
		continuing
	research	
	perinatal outreach program	
	others	genetic counselling
		infertility

SUPPORT DEPARTMENTS		
	biomedical engineering	
	community nurse liaison	
	imaging technology	angiography
		CAT scan
		nuclear medicine
		radiography
		ultrasound
	laboratory services	biochemical lab (microtechnique)
		electroencephalography

hematology (including blood bank)
microbiology

pathology services
medical specialties
occupational therapy
pastoral care
pharmacy
physiotherapy
respiratory technology
social service
screening — auditory
metabolic
developmental follow-up and care
therapeutic dietetics
surgery and surgical specialties related to pediatrics and reproductive care

APPENDIX D: CENTRAL FOOD COMMISSARY SYSTEM IN SASKATOON

Background

Consideration of establishment of a central food commissary serving special care homes and hospitals in Saskatoon was initiated by the Sherbrooke Community Centre as a result of its plans to construct new facilities, including a kitchen. The question arose as to whether development of a full-scale kitchen by each institution in Saskatoon was desirable and needed or whether it made more economic sense to establish a central commissary, serving a number of institutions.

A Task Force Committee to investigate the desirability and feasibility of establishing a central food commissary was formed in the fall of 1989. The Task Force Committee is comprised of representatives from the following organizations: Sherbrooke Community Centre, Saskatoon City Hospital, Royal University Hospital, Parkridge Centre, District Home Care, Lutheran Sunset Home and Saskatoon Convalescent Home. Boris Kishchuk, an independent consultant, is serving as chairman.

Work Carried Out to Date

The following summarizes the work the Task Force Committee and individual members have accomplished to date:

- Receipt of data on food services costs per resident day from nine special care home operating in Saskatoon.
- Receipt of data on food services costs per patient day from nine hospitals located in Saskatoon, Edmonton, Red Deer, Kingston and Ottawa.
- Visitations to the central food commissaries operating in Ottawa, Edmonton and Victoria including visits to the "clients" of the commissaries - i.e., hospitals, nursing homes, long term stay facilities.
- Discussions and meetings with potential participants of a food commissary system in Saskatoon and with Saskatchewan Health officials.

Recommendations Accepted by the Task Force Committee

The following recommendations have been accepted by the Task Force Committee:

1. A formal feasibility study to be carried out to determine the capital and operating costs of a central commissary system in Saskatoon and to determine the threshold levels of production that would be required to operate a commissary system on a viable basis.
2. To request the support of Saskatchewan Health in investigating the establishment of a central commissary system, including financial support.
3. Approach non Task Force Committee organizations to determine their interest in participating in the feasibility study.
4. Obtain commitments from participating organizations to pay for the feasibility study.
5. Commission an appropriate food services consultant to conduct the study.

Present Situation

Draft terms of reference to carry out a feasibility study for a central food commissary system in Saskatoon have been prepared. However, full financial commitments to pay for the study have not yet been obtained.

- Three special care homes have given their commitment to contribute financially.
- One hospital has given its commitment of financial support; one hospital indicated it will support the study, provided the province also contributes; the third hospital has indicated support in principle, but says it is unable to support the study financially.
- Saskatchewan Health has not, to date, committed support for the study. We understand that they are awaiting a recommendation from the panel and Saskatchewan Commission on Directions in Health Care.

Assistance Requested from the Saskatchewan Commission on Directions in Health Care

The support of the panel investigating health services in Saskatoon and the Saskatchewan Commission on Directions in Health Care to determine the feasibility of establishing a central food commissary in Saskatoon is respectfully requested. A central commissary system has the potential for serving not only organizations/institutions located in Saskatoon, but the surrounding region as well. The preliminary estimated cost of the study is $80,000.

Boris W. Kishchuk, Croscan Consulting Services, for the Task Force Committee

APPENDIX E: TABLE 1

SASKATOON HOSPITALS

PATIENT DISCHARGES, VISITS AND DIAGNOSTIC SERVICE VOLUMES

1988-1990

	RUH	SCH	SPH
Patient Discharges and Visits			
Inpatient discharges	17,543	13,483	14,786
Emergency visits	25,027	42,534	51,935
Ambulatory clinic	126,791	24,599	8,411
Day surgery	6,275	10,166	8,293
Renal dialysis	1,195	- -	4,400
Rehabilitation visits	68,735	25,754	18,174
Respiratory visits	648,928	10,564	31,738
TOTAL	894,494	127,100	137,737
Diagnostic Services			
Nuclear medicine	9,702	- -	- -
Diagnostic imaging	3,291,608	33,778	46,686
Laboratory	8,858,876	2,715,322	3,536,246
Vascular laboratory	- -	- -	889
Test centre	- -	- -	2,994
TOTAL	12,160,186	2,749,100	3,566,815

Source: Information provided by each Saskatoon hospital.

TABLE 2

SASKATOON HOSPITALS

BED INVENTORY AND OCCUPANCY RATES

Bed Type	Beds Available	Beds Set Up	Beds Occupied	Beds Not Occupied	Beds Needed for 85% Occupancy (Common Standard)	Beds Not Needed with 85% Occupancy Rate
Maternity	101	94	71	30	86	15
Neonatal ICU	29	29	27	2	25	4
Pediatrics	128	118	72	56	109	19
Pediatrics ICU	4	5	5	0	5	0
General medicine	312	335	302	10	265	47
CCU	22	14	11	11	19	3
ICU	26	30	23	3	22	4
Neurosurgery	39	39	27	12	33	6
Geriatric	18	18	18	0	15	3
Long term care	63	65	46	17	54	9
Palliative care	12	12	9	3	10	2
Physical rehab.	21	21	19	2	18	3
General surgery	228	190	158	70	194	34
Gynecology	80	72	49	31	68	12
Burn unit	5	5	0	5	4	4
Ophthalmology	24	24	16	8	20	4
Ear, Nose, Throat	27	27	15	12	23	3
Urology	69	70	56	13	59	10
Orthopedics	111	123	90	21	94	17
Dental/Plastic	18	18	12	6	15	3
Psychiatric	69	69	68	1	59	10
TOTAL	1,406	1,378	1,094	313	1,197	212
Occupancy Rate			77.8%		85%	

Source: Information provided by each Saskatoon hospital.

Note: ICU: Intensive Care Unit; CCU: Cardiac Care Unit

TABLE 3

SASKATOON HOSPITALS

SUMMARY OF PATIENT SEPARATIONS BY DOCTOR SERVICE

Type	RUH		SCH		SPH		Total	
Family Practitioner	566	5%	4,325	36%	6,966	59%	11,857	30%
Internist	167	9%	761	42%	870	49%	1,798	4%
Cardiologist	1,148	80%	- -		294	20%	1,442	3%
Nephrologist	260	66%	- -		131	34%	391	1%
Pediatrics	2,618	77%	298	9%	458	14%	3,374	7%
General Surgery	1,673	27%	2,154	35%	2,349	38%	6,176	14%
Neurosurgery	762	78%	182	19%	25	3%	969	2%
Orthopedics	1,525	40%	1,169	30%	1,135	30%	3,829	8%
Plastics	943	67%	263	19%	196	14%	1,402	3%
Urologist	724	25%	997	34%	1,171	41%	2,892	6%
Obstetrician/gynecologist	2,978	47%	1,406	22%	2,011	31%	6,395	14%
Ear, Nose, Throat	395	14%	1,280	47%	1,052	39%	2,727	6%
Ophthalmologist	709	37%	431	23%	755	40%	1,895	4%

Source: Information provided by each Saskatoon hospital.

TABLE 4

SASKATOON HOSPITALS

PATIENT SEPARATIONS BY MAJOR CLINICAL CATEGORIES

1988-89

	RUH	%	SCH	%	SPH	%	Total
01 Nervous System	1345	60	464	20	444	20	2253
02 Eyes	724	37	431	23	779	40	1934
03 Ear, Nose, and Throat	549	17	1426	44	1241	39	3216
04 Respiratory System	1027	39	602	22	1023	39	2652
05 Circulatory System	1911	49	873	22	1142	29	3926
06 Digestive System	1520	29	1822	34	1991	37	5333
07 Hepatobiliary System and Pancreas	456	35	430	33	432	33	1318
08 Musculoskeletal System and Connective Tissue	2294	46	1342	27	1310	26	4946
09 Skin, Breast and Subcutaneous Tissues	577	39	436	29	483	32	1496
10 Endocrine, Nutrition and Metabolic System	354	41	190	26	262	33	806
11 Kidney and Urninary Tract	546	30	494	27	775	43	1815
12 Male Reproductive System	370	24	570	37	591	39	1531
13 Female Reproductive System	698	24	1033	35	1180	41	2911
14 Pregnancy, Childbirth and Puerperium	2248	33	1539	23	2939	44	6726
15 Newborn and Neonates	1730	35	1067	22	2095	43	4892
16 Blood and Blood Forming Organs and Immunological Disorders	132	38	74	21	146	41	352
17 Myeloproliferative Diseases and Neoplasma	518	72	57	8	148	20	723
18 Infectious and Parasitic Diseases	118	32	104	28	150	40	372
19 Mental Diseases and Disorders	537	57	347	37	54	6	938
20 Substance Use and Drug-Induced Mental Disorders	20	21	41	42	36	37	97
21 Injuries, Poisionings and Toxic Effects of Drugs	493	54	184	20	242	26	919
22 Burns	82	82	6	6	12	12	100
23 Factors Influencing Health Status	141	46	41	13	127	41	309
TOTAL	18,390	37%	13,573	27%	17,602	36%	49,565

Source: Hospital Medical Records Institute, and information provided by each Saskatoon hospital.

TABLE 5

SASKATOON HOSPITALS

LENGTH OF STAY PROFILE 1988-1989

ITEMS	RUH	SCH	SPH
Separations	15,845	12,094	15,149
Days	138,531	85,431	93,581
Average length of stay	8.7 days	7.1 days	6.2 days
Discharge by Age			
0-14	14%	13%	15%
Average length of stay	6.0 days	3.7 days	3.3 days
15-34	31%	30%	32%
Average length of stay	6.7 days	4.1 days	3.9 days
35-44	10%	10%	9%
Average length of stay	8.6 days	5.4 days	4.7 days
45-64	21%	18%	17%
Average length of stay	10 days	7.9 days	7.5 days
65 +	25%	29%	27%
Average length of stay	11.9 days	11.6 days	10 days
Deaths	443	322	328
Average length of stay	15.7 days	27 days	20.5 days
Separation by Categories	%	%	%
Indian	9	5	7
Non-resident	68	47	37
Emergency admission	53	12	65
Urgent admission	15	12	14
Surgical admission	62	80	91
Preoperative average length of stay	2.0 days	1.2 days	1.4 days

Source: Length of Stay Profile for Medical Diagnosis, Period April 1988 to March 1989. S.H.A.R.E. System Saskatchewan General Hospitals (excludes Level 4 and psychiatric units). Hospital Services Branch, Saskatchewan Department of Health.

TABLE 6

SASKATOON HOSPITALS

REFERRAL STATISTICS

	RUH		SCH		SPH	
All discharges	15,782		12,100		15,236	
All days	141,047		92,044		98,864	
Average length of stay (ALOS)	8.9		7.6		6.5	
Saskatoon resident discharges	4,881	(31%)	6,248	(52%)	9,083	(60%)
Saskatoon resident days	41,122		49,486		58,042	
Saskatoon resident ALOS	8.4		7.9		6.4	
Non-Saskatoon resident discharges	10,901	(69%)	5,852	(48%)	6,153	(40%)
Non-Saskatoon resident days	99,925		42,558		40,822	
Non-Saskatoon resident ALOS	9.1		7.3		6.6	

Source: Hospital Services Branch, Department of Health
Saskatchewan Hospital Services Plan Statistics April 1988 to March 1989.

TABLE 7

AMBULATORY DAY SURGERY

SASKATOON HOSPITALS

1988 - 1989

I. All surgical procedures.

		Inpatient		Day Surgery	
	Cases	Cases	%	Cases	%
RUH	23,230	17,897	77	5,333	23
SCH	22,235	13,473	61	8,762	39
SPH	22,661	17,611	78	5,050	22
TOTAL	68,126	48,981	72	19,145	28

II. Selected procedures appropriate for ambulatory day surgery. (A list of selected procedures prepared in co-operation with the three hospitals was used to analyse the appropriateness of inpatient admissions for certain surgical procedures.)

	Procedures Inpatient and Day Surgery	Day Surgery		Inpatient Surgery		Questionable * Inpatient Surgery	
	Cases	Cases	%	Cases	%	Cases	%
RUH	6,239	3,314	53	1,690	27	1,235	20
SCH	9,389	6,463	69	1,220	13	1,706	18
SPH	7,414	3,635	49	1,286	17	2,493	34
TOTAL	23,042	13,412	58	4,196	18	5,434	24

	Inpatient Surgery		Questionable * Inpatient Surgery	
	Days	ALOS **	Days	ALOS
RUH	23,184	13.7	2,564	2.1
SCH	13,921	11.4	3,618	2.1
SPH	11,929	9.3	4,474	1.8
TOTAL	49,034	11.7	10,656	2.0

* Questionable means the case had a procedure considered safe for ambulatory surgery and the patient was admitted and discharged within three days indicating the patient did not have medical complications requiring an inpatient stay.

* * ALOS means Average Length of Stay.

Source: Hospital Services Branch, Saskatchewan Health database 1988-89.

TABLE 8

SASKATOON HOSPITALS

NORMAL NEWBORNS AND NEONATES WITH COMPLICATIONS

NARRATIVE	RUH	SCH	SPH	TOTAL
Normal newborn no complications	773 (21%)	998 (28%)	1,825 (51%)	3,596
Full term normal neonates with complications	104	9	56	169
Neonates with significant problems	374	23	147	544
Prematurity without complications	21	19	26	66
Prematurity with complications	143	2	6	151
Extreme immaturity, neonates	131	- -	2	133
Neonates transferred	152	13	24	189
TOTAL *	1,698 (35%)	1,064 (22%)	2,086 (43%)	4,848

Source: Information provided by each Saskatoon hospital for 1988-1989.

* *Note*: Difference between these totals and those given in Major Clinical Category 15, Table 4, is due to anomalies in data collection.

APPENDIX F: STUDY PANEL MEETINGS

March 15, 1990	J. Atkinson, R. Coombs, P. Kiovsky, J. MacKay Dr. R. Murray, W. Podiluk	First Panel Meeting Study Panel Saskatchewan Health Care Commission
April 2, 1990	K. Clarke, T. Dagnone, E. Schwartz, W. Podiluk, Dr. R. Murray P. Kiovsky	Hospital Presidents Saskatchewan Health Care Commission Study Panel
April 4, 1990	Dr. D. Kendel Dr. E. Baergen Dr. R. Murray, W. Podiluk	College of Physicians and Surgeons Saskatchewan Medical Association Saskatchewan Health Care Commission
April 17, 1990	L. Dube, I. Buckwold, Sister R. Gauvin, U. Donlevy, Sister J. Thevenot, Bishop J. Mahoney, G. Archibald, Dr. V. Holmes, K. Clarke, J. O'Shaughnessy, B. Olineck, Dr. R. Baltzan	St. Paul's Hospital Board of Governors
April 17, 1990	L. Dube, I. Buckwold, K. Clarke, J. O'Shaughnessy, Dr. R. Baltzan, Dr. S. Chary, Dr. B. Lawlor, Dr. G. Pylpychuk, Dr. V. Malliah	St. Paul's Hospital Liaison Committee
April 18, 1990	J. Scissons, K. Ford, E. Schwartz, Dr. G. Bray, P. Krutzen, B. Davidson, Dr. A. Harris, F. Hartman, P. Lorje, B. Rourke, B. Miller, J. Hills, R. Rodda, P. Robertson, W. Kallio	Saskatoon City Hospital Board of Governors
April 19, 1990	B. Ayers, J. Cross, B. Emigh, Dr. F. Gathercole, B. Holmlund, Dr. I. McDonald, E. Cameron, J. McKenzie, D. Smith, B. Spooner, T. Dagnone	Royal University Hospital Board of Governors
April 19, 1990	B. Ayers, T. Dagnone, Dr. D. Popkin, Dr. W. Bingham, J. McKenzie, B. Spooner, P. Kehl, M. Kohlhammer, D. Paulson, Dr. S. Smith	Royal University Hospital Liaison Committee

May 7, 1990	Hon. G. McLeod Dr. W. McDonald	Minister of Health Deputy Minister of Health
May 7, 1990	Dr. P. Duncan	Anesthesia Royal University Hospital
May 7, 1990	Dr. I. McDonald, Dr. D. Popkin, Dr. D. Johnson, S. White, E. Grogin J. Blackburn V. Cottress M. Montgomery P. Innis	College of Medicine College of Medicine College of Nursing College of Pharmacy College of Physical Therapy Saskatchewan Institute of Applied Science and Technology College of Dentistry
May 8, 1990	J. Scissons, K. Ford, Dr. B. McIvor, E. Schwartz, Dr. E. Somerville, R. Rodda, J. Hill, R. Grise	Saskatoon City Hospital Liaison Committee
May 8, 1990	Drs. A. Doig, R. Gore-Hickman, C. Boyle, S. Scharfstein, B. Gilliland, G. Ducasse, K. Romanchuk, A. Enright, L. Rivers	Ad Hoc Committee of Saskatoon City Hospital Physicians
May 8, 1990	B. Ayers, Dr. D. Popkin, Dr. W. Bingham, J. McKenzie, B. Spooner, P. Kehl, M. Kohlhammer, D. Paulson, J. Colvin, Dr. S. Smith	Royal University Hospital Liaison Committee
May 9, 1990	L. Dube, I. Buckwold, K. Clarke, J. O'Shaughnessy, Dr. R. Baltzan, Dr. S. Chary, Dr. V. Malliah, Dr. B. Lawlor, Dr. G. Pylpychuk, Dr. R. Weiler, P. Brackstone, T. Molloy	St. Paul's Hospital Liaison Committee
May 9, 1990	Dr. M. Bala	Chief of Medicine, Royal University Hospital
May 10, 1990	Conjoint Group Meeting J. Scissons, Dr. D. McIvor, E. Schwartz L. Dube, Dr. R. Baltzan, K. Clarke B. Ayers, Dr. S. Smith, T. Dagnone Dr. I. McDonald, Dr. D. Popkin Dr. K. Haight	 Saskatoon City Hospital St. Paul's Hospital Royal University Hospital College of Medicine

May 21, 1990	Dr. R. Schneider	Ophthalmology, Royal University Hospital
May 21, 1990	Dr. L. Massey	Pathology, Royal University Hospital
May 22, 1990	Dr. H. Goldberg	Ophthalmology, Royal University Hospital
May 22, 1990	Dr. D. Kendel	College of Physicians and Surgeons of Saskatchewan
May 22, 1990	F. Clark, L. Galenzoski, L. Sincaryk, P. Turtle	St. Paul's Hospital Nursing Staff
May 31, 1990	Dr. C. Ewing	Ophthalmology, Royal University Hospital
June 11, 1990	L. Dube, Sister R. Gauvin, Sister F. Wylie, Dr. R. Baltzan, I. Buckwold, K. Clarke	St. Paul's Hospital Board Members
June 14, 1990	M. Deacon, L. Bray, D. McLashen, M. Turnball, J. Skwarchuk, D. Topp, M. Pulles, V. Ostoforoff, S. Carriere, D. Ferleski, M. Krauss, S. Kuling, M. Lockhart, A. Hauser, R. Furber, J. Elash, U. Hilligweg, M. Friesen, M. Benson, C. Bell, M. Scheirich, L. Clark, P. Marken, W. Stefiuk	Saskatchewan Union of Nurses, Local 75 Royal University Hospital Nursing Staff
June 14, 1990	Dr. I. McDonald, Dr. D. Keegan, K. Clarke, Dr. J. Elias, J. O'Shaughnessy, B. Spooner, K. Layng, N. Gardner	Psychiatric Work Group
June 14, 1990	J. Colvin, J. O'Shaughnessy, T. Archibald, J. Landry, E. Marlow, N. Gardner, K. Layng	Geriatric/Rehabilitation Task Group
June 14, 1990	N. Gardner, K. Layng	Hospital Services Branch Saskatchewan Health
June 15, 1990	L. Spizawka, J. McKee, V. Bagnall, J. Junor	Saskatoon City Hospital Nurses

June 15, 1990	Conjoint Group Meeting J. Scissons, Dr. D. McIvor, E. Schwartz	Saskatoon City Hospital
	L. Dube, Dr. R. Baltzan, K. Clarke	St. Paul's Hospital
	B. Ayers, Dr. S. Smith, T. Dagnone	Royal University Hospital
	Dr. I. McDonald, Dr. D. Popkin Dr. K. Haight	College of Medicine
June 27, 1990	Dr. M. Shokeir	Pediatrician, Royal University Hospital
June 27, 1990	B. Kishchuk E. Marleau	Croscan Consulting Services Sherbrooke Community Centre
June 27, 1990	P. Peterson, Dr. D. White, Dr. E. Kostashuk	Cancer Foundation
June 27, 1990	Conjoint Group Meeting J. Scissons, Dr. D. McIvor, E. Schwartz	Saskatoon City Hospital
	L. Dube, Dr. R. Baltzan, K. Clarke	St. Paul's Hospital
	B. Ayers, Dr. S. Smith, T. Dagnone	Royal University Hospital
	Dr. I. McDonald, Dr. D. Popkin Dr. K. Haight	College of Medicine
June 27, 1990	Dr. R. Keith	Chief of Surgery, Royal University Hospital
June 28, 1990	Dr. T. MacLachlan	Royal University Hospital
June 28, 1990	Drs. Z. Alvi, P. Gore-Hickman, B. Maber, P. Modi, G. Wright, D. Will	Otolaryngologists of Saskatoon
June 28, 1990	Dr. R. Murray, W. Podiluk, E. Moen, B. Farr, M. Anderson, Bishop B. Morand	Saskatchewan Commission on Directions in Health Care

APPENDIX G: NOTES AND REFERENCES

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